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A CONTRIBUTION TO THE STUDY OF
PSYCHOSES IN YOUNG PEOPLE WITH
SPECIAL REFERENCE TO PROGNOSIS.



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"The factors which determine that a process
is non-reversible still furnish the central
problem in psychiatry." ⁽¹⁾

THESIS

This thesis is concerned with the occurrence of acute psychotic reactions in adolescents and young adults. The study of the causation, the symptoms, and the course of these reactions, furnishes a series of problems of importance and interest. The thesis depends on the examination of the psychoses as reactions brought on by an interplay of the social environment and the individual endowment.

The fundamental problem that is discussed is the problem of prognosis. The question that we will address ourselves to is the question of what the prognosis depends on in these reactions. There are various subsidiary questions, each in itself a method of approach to the main problem. For example, the factors which conduce to a recovery are fully discussed and the factors which constitute a basis of malignancy in the reactions are considered. The problems are approached by an examination of the evidence manifested in the endowment of character and personality, in the environmental circumstances, and in the psychotic reaction itself. The points suggestive of the reaction being of a more easily recoverable nature are evaluated along with those which might indicate that the final and satisfactory social adjustment is more difficult of achievement.

The problem of the relation to prognosis of the character and personality, the environmental circumstances, and the psychiatric symptomatology may be approached/

approached in many ways. What are the best methods of approach? In what way, for example, should the pre-psychotic personality be assessed? To what extent in the majority of cases is it possible to arrive at a satisfactory estimate of the type of pre-psychotic personality or the adequacy of the pre-psychotic character? To what extent is it the case that the better the pre-psychotic adjustment, the better the prognosis? Can the pre-psychotic history be regarded as a reliable guide to prognosis? To what extent can mental illness or eccentricity in the parents or ancestry be taken as a guide to the unsoundness of the individual endowment?

The study of the environmental circumstances similarly raises many points. Can abnormality in the reactions of the parents be considered also in this connection? Can the reactions in some such cases indicate an understandable reaction in the circumstances, or is the parental abnormality more suggestive of the likelihood of a bad endowment in the offspring and of the probability that an illness occurring in early life is likely to be malignant in proportion to the eccentricity of the parents? If patients come from a part of the country where there is a greater tendency to psychotic reactions, is it likely that the majority will not recover on account of their coming from a bad stock, or is it likely that the factors that in other people would lead to adolescent emotional difficulties of a minor nature/

nature, lead, in such people, to a frank psychotic reaction and that this reaction is therefore a temporary upset. In the case of patients who have espoused strange beliefs, or have been interested in strange sects, can it be assumed that there has been an insidious tendency to abnormal thinking indicative of a progressively asocial type of reaction? Or does the fact that a patient has for long been involved in, say, spiritualistic beliefs indicate that the psychosis is not so bad as it looks, that the patient is not so ill, having regard to his usual standard of mental health, and that as he has been associated with others in the abnormal trend of beliefs, so he may be influenced by others towards a recovery?

With regard to the study of the patient in the psychosis, there are also many factors to consider. Is an acute onset always of good prognosis, or sufficiently so to serve as a useful guide? If regression is not a true indication of a bad prognosis, is it any guide at all? How should a stupor reaction be assessed in terms of prognosis? Is apparent absence of affect a bad sign? Is preservation of affect always a good sign? Can the extent to which affect is present always be assessed with any degree of confidence? Can any of the features of the psychosis be regarded with any degree of confidence as of good or bad prognosis? Is the acute recoverable schizophrenia of young people a true condition? Do/

Do cases of chronic depression occur, beginning in youth? Is it legitimate to divide all cases of psychosis occurring before the age of thirty between the manic depressive group and the schizophrenic group? Is it to be recommended that these names should carry as much prognostic significance as they are accustomed being accorded? Is it possible to continue the use of these terms without such implications having regard to the tenacity with which the diagnosis and course have clung together in spite of all efforts at separation?

It is generally appreciated that a prognostic classification has more disadvantages and advantages and that diagnosis by outcome is wholly unsatisfactory. The disadvantages of a prognostic classification have been a constant subject of dissension for the past thirty years, and diagnosis by outcome has been held up to ridicule. At the same time the present methods are but modifications of the methods of classifying by prognosis and diagnosing by outcome. The current practice is somewhat as follows:

If the examiner's bias is in favour of basing a prognosis on the features of the psychosis, he first assesses the relative prominence of manic-depressive and schizophrenic features and then makes a diagnosis which bears great prognostic significance since the manic depressive elements are equivalent to the more favourable prognostic signs and the schizophrenic to the less favourable. If the manic depressive patient recovers and the schizophrenic/

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schizophrenic patient dement, then the diagnosis is supported by the course. If, on the other hand, the manic depressive patient proceeds to dementia, the diagnosis requires to be changed although the schizophrenic patient may be allowed to recover without the necessity of change of diagnosis.

If the examiner's bias is in favour of basing prognosis mainly on the pre-psychotic history, he first arrives at an estimate of the comparative adequacy of the adaptation, assesses the prognosis on this estimate, and calls the patient "manic-depressive" or "schizophrenic" according to the prognosis already arrived at.

There is sufficient truth in this account of present methods of diagnosis and prognosis to make it clear that the criticisms of the more rigid type of prognostic classification have not had the desired effect.

If the term "schizophrenia" is to be robbed of much of its prognostic importance, then an assessment of the prognosis on the basis of the psychosis, or the pre-psychosis, being so much schizophrenic and so much manic-depressive psychosis will no longer be valid. Are the essentially schizophrenic and the essentially malignant the same? If not, then the term "schizophrenia" can embrace recoverable conditions. How wide should the net be cast? Are all cases of malignant psychosis occurring in young people cases of schizophrenia? If so, is it reasonable to hammer away at/

at the necessity of separating diagnosis from prognosis? If cases other than schizophrenia occur in youth and run a malignant course, can the division remain, or must a new search be made for the essential and fundamental characters of the psychosis?

If there is so much misgiving with regard to diagnosis, is prognosis in a better position? Are the prognostic principles of the past thirty years justified? Is a prognosis based on the psychosis and the pre-psychotic history sufficiently accurate to permit us to be satisfied with the present methods, or are such studies as the present merely indicative of an awareness of the limitation of present methods and of an admission that the secant of reversibility in the psychoses must await the development of psychopathology, or of the methods of psychometry, biophysics and biochemistry?

In the present contribution, the psychosis is considered in relation to the life situation. This relationship is studied with a view to finding indications of importance for prognosis. It should be made clear that in the selection of case material, the less malignant rather than the more malignant have been chosen. The approach to the study of the prognosis can be made in two ways. One way is to attempt to establish the essential signs of malignancy, to search for what are assumed to be the essentially malignant features, and to assess the prognosis on their relative prominence. This is best done in association with a report of cases which are/

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are running a chronic course. In the present contribution, the other method is chosen; namely, an attempt is made to estimate the value of what may be considered to be favourable signs in the pre-psychotic history, the onset of illness, and the features of the psychosis. Reports are given of groups of cases where such favourable signs can be noted. By means of brief historical surveys, the development of the present-day methods of approach to the problem of prognosis is studied. It is hoped that if this thesis were read by anyone unfamiliar with twentieth century methods in psychiatry, it would prove sufficiently comprehensive for the value of the approach to mental illness in terms of the life situation and the psychobiological reaction to be appreciated. If present-day methods have their limitations, it is surely because the deeper implications in the psychobiological approach have yet to be realised.

It is my belief that an examination of the psychosis in its relation to the environmental circumstances and the development of the individual from childhood is as important in the study of mental illness as is the examination of the symptoms and physical signs in relation to gross pathology in the study of physical diseases. On this basis an attempt is made to indicate the possibilities of prognostic forecasts.

An examination of the psychosis in relation to the development of the individual in early childhood

may prove more analogous to the study of sickness
in relation to the finer pathology of disease, and
may reveal methods of surer guidance in prognosis.
This thesis is not concerned with any such study.

INTRODUCTION TO A HISTORICAL SURVEY

In reviewing the various factors that influence prognosis, it is important to note the relation to various schools of present-day thought and it is impossible to appreciate present-day viewpoints without recognising the process of their evolution. As far as is possible, the material is selected with a view to throwing light on the prognosis in adolescents and young adults.

If we **concentrate** our attention on the beliefs which were held dogmatically and are now discounted without being replaced, and on the similarity between certain of the nineteenth century viewpoints and these of the present day, it may seem that little progress has been made and that the tendency has been for viewpoints to change rather than to advance.

If, however, the limitations of descriptive methods are apparent, then the difficulties in the dogmatic use of descriptive terms becomes more obvious and the field is left open for the consideration and acceptance of progressive ideas.

Let us examine the changing viewpoints of the past fifty years. The nineteenth century psychiatrists as exemplified by Clouston, arrived at diagnoses without prognostic implication. In melancholia, in mania, and in melancholic stupor about/

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about fifty per cent of the cases were considered to make satisfactory recoveries and in about fifty per cent the primary condition was followed by a secondary dementia.⁽²⁾ It is not important to consider at present to what extent these terms conformed in their use to the same terms as used to-day. The point of interest is that each had a minimum of prognostic significance attached to it. Kraepelin introduced a prognostic classification and present-day usage follows his methods as modified by forty years of critical study. An early modification of the strict Kraepelinian methods was introduced by Meyer in 1906.⁽³⁾ His remarks include criticisms of the term dementia praecox, since he believed that cases should not be designated with a term of the possible or even probable outcome.

Too much attention cannot be paid to Meyer's views on prognosis including his criticisms of the method of keeping too close an association between diagnosis in prognosis. His views form the background of the greater part of the work that is here referred to. It may therefore not be out of place to give a very brief resume of his views as found in his published articles of 1906,⁽³⁾ 1917⁽⁴⁾ and 1922.⁽⁵⁾

Meyer's Views on Prognosis

with Special Reference to Schizophrenia.

In 1906 Meyer⁽³⁾ said that it should be borne in mind that the concept of dementia praecox had better be looked on as designating a perspective of deterioration which was thereby the most important feature in many cases. He pointed out, however, that in many cases the deterioration is not imminent, nor the most interesting feature; it is a result to be borne in mind and to be dreaded, but not as directly interesting as the process which threatened miscarriage. He thought that in a fairly large number of cases the process should be designated not with a term of the possible, or even probable outcome, but with one designating the principle at work - the hysteroid reaction, the abnormal habit reaction, the type of attention defect and of judgement defect. After the introduction of the term schizophrenia, the condition continued to be regarded as much in terms of course and probable outcome as in terms of the morbid processes at work, and in 1917 Meyer⁽⁴⁾ again emphasised the necessity of subordinating the prognostic verdict into a more constructive question, that of the problem of therapeutic modifiability, which in turn should be subordinated to the study of the working of all the dynamic factors and the structural and functional descriptive facts. None of the recognisable/

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recognisable types of psychotic reaction, he pointed out, are wholly exempt from the possibility of chronicity or even a certain amount of deterioration. There are always some manic-depressive cases which become chronic and even some which show more and more a constitutional deficit, and others actually a certain decline in the course of the years, not altogether distinguishable from that in more clearly schizophrenic states. Similarly he pointed to a fair number of cases with manifestations clearly of the type usually giving the unfavourable prognosis of the standard dementia praecox process that get well. He considered that mental disorders could not profitably be studied with an excessive emphasis on a prognostic classification according to outcome, and said that it would seem better not to consider the course and outcome as a fixed state in any of the disease types unless we could be able to get at the nature of the process so as to measure it with reasonably unmistakeable evidence of the facts in each case.

Meyer's views have been supported by the publication of reports by a number of psychiatrists of cases which had been diagnosed as cases of schizophrenia where recovery had taken place. The earlier cases on record mainly consist of catatonic states, with stupor as the most prominent phase. It is very well worth while to review the status of the stupor/

stupor reaction during the past half century or rather more. In this review, attention has been concentrated only on the more outstanding pronouncements. The views of Hayes Newington⁽⁶⁾ and Clouston⁽⁷⁾ are first considered. The dates are 1874 for the publication of Hayes Newington's article, and the eighties for the publication of the earlier editions of Clouston's textbook. Kraepelin's classification is mentioned and the next important dates are the dates of publication of the articles by Kirby⁽⁸⁾ and Henderson⁽⁹⁾ in 1913 and 1916 respectively which reveal an application of the Meyerian principles of prognosis. The history of the stupor reaction is next punctuated by the publication of Hoch's book "Benign Stupor" in 1921.⁽¹⁰⁾ There are four distinct and separate viewpoints. At present we have the similar yet divergent views of Henderson⁽¹¹⁾ and Lewis.⁽¹²⁾ The present-day views have more in common with those of Clouston^(8 and 13) and Kirby than with the views of Kraepelin and Hoch.

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HISTORICAL SURVEY WITH SPECIAL REFERENCE

TO THE "STUPOR REACTION".

Clouston called most cases to stupor "melancholic". "Melancholic stupor", he said, "is by far the most frequent and the most important form". There was another form which, following Hayes Newington, he called "anergic", which word describes "the passive, unconscious, non-depressed cases". When stupor followed another mental illness, he referred to it as "Secondary Stupor".

Of prognosis he says: "In its typical form, in young persons of both sexes, the anergic form (acute dementia) is a very curable form of mental disease. The melancholic form is not so curable, but about 50 per cent of the cases recover".

The anergic cases apparently show an acute wholesale kind of regression of sudden onset. They lie passive, unresisting, unresponding, and apparently unconscious, with no bizarre signs, no incongruity of behaviour. There is no sporadic aggression, or evidence of internal conflicts. There is a minimum of distortion, since the psychosis is but an exaggerated state of sleep, a kind of trance. Hayes Newington⁽⁶⁾ regards "absence of cerebration" as the most essential feature in contrast to the "abnormal presence of intense but perverted cerebration" as the essential feature of the melancholic form.

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The majority of cases/Clouston called "melancholic" refer to the form that Hayes Newington called Delusional putting in brackets Melancholic Type which apparently referred to an older classification since Acute Dementia Type is similarly put in brackets after the term Anergic. Fifty per cent of these cases recover, and Clouston makes no attempt to divide the benign from the malignant. "Melancholic cases are sometimes suddenly impulsive at one period of the disease, and it is well to remember that during convalescence they may be suicidally impulsive. Gusts of motor energy seem suddenly to be evolved in the brain". It may be concluded that the melancholic group included these that might be subject to catatonic outbursts. Clouston⁽⁷⁾ gives four cases. Although Hoch clearly states that his benign group is the same as the anergic group of Hayes Newington, there can be no doubt that these four cases of "melancholic stupor" could have been given word for word in Hoch's book as benign stupors. They would not have differed from his cases in any important point. In two cases, ideas of death were prominently expressed at the onset of the stupor, and in the other two cases attempts at suicide were made at the same stage. The ideas of death were prominent in this case:-

"He became sleepless, nervous, and much depressed. He first spoke constantly about his being victimised and/
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"and cheated, and then expressed delusions that he was in debt and that he must go to the police office and give himself up. His delusions by and by referred to his body.... and he said that his inside was burnt out.He would appear as if he were about to speak or answer a question, but the volitional power seemed to fail him and he would say nothing. His next delusion was natural enough, the wish being father to the thought - he fancied he was dead, and he would say 'I am dead; put me in my grave'. Then for two months his stupor was complete, with no outward expression of mentalisation at all. But the expression of face was melancholic as well as stupid and there was muscular resistance. He lay in bed. All this time he was getting weaker..... The news of his favourite daughter's death did not affect him. I have no doubt he had the delusion he was dead. He got thinner and weaker, and gangrene of his heel appeared; then hypostatic pneumonia, and, lastly, gangrene of the legs, of which he died eight months after admission".

of the "melancholic type"

Another of Clouston's cases/was of three years' duration, during which time the patient was fed twice a day with the stomach tube. He was in a condition of "absolute stupor, lying motionless, insensible to pain, unable to stand, his urine and faeces dribbling away, his circulation feeble, offering/

"offering no resistance to anything done to him, and taking no notice apparently of anything..... Nothing could rouse him;nothing could excite any mental or bodily response, except that he shut his eyes tightly when the eyeballs were touched and there was slight motion of the legs when the soles of his feet were tickled, but this last reflex power disappeared in October 1878. Much difficulty was experienced in keeping him warm, but an old and most affectionate maiden aunt, who came to see him almost daily, contrived the most wonderful foot coverings and body rugs. He was dressed in the morning, carried down to a sofa, and his penis inserted into an indiarubber bottle; there he lay all day, never moving, never resisting anything done to him." This went on for three years when he recovered. "He seemed the most complete case of "acute dementia" or anergic stupor I ever saw" says Clouston, "except for two things; these were, a certain expression in his face, which was never so absolutely blank as it is in that condition, and his not being able to stand or move at all, which seldom occurs. There was none of the resistance or muscular rigidity of melancholic stupor."

Complete inability to stand or move at all, any emotional expression, resistance or muscular rigidity or the presence of delusions seemed to be sufficient to exclude a case from the anergic and to put it into the melancholic group. The anergic group was therefore/

therefore a carefully guarded collection.

What was melancholia to Clouston, was dementia praecox to Kraepelin, but after the Kraepelinian avalanche, more accurate diagnostic distinctions were picked up again, Meyer's paper of 1906 being an early reaction in favour of discarding prognostic principles in diagnosis. The clearest account of the application of this method is in Kirby's paper of 1913.⁽⁸⁾ He there uses the term katatonia without prognostic significance, but differentiates within this group cases of varying degrees of seriousness. A bad prognosis can be predicted on the basis of a prodromal period of change in the personality, although the change in personality criterion is open to two modifications. Two cases without such a change proceeded to deterioration, both being puerperal cases. A more important modification, and one which might be thought capable of seriously detracting from the importance of the prognostic significance of previous change in the personality, is the indication he gives that this personality change may be learned only by a process of anamnesis on the part of the patient. At the other extreme, there is the group where a good prognosis is indicated on account of the presence of manic-depressive features in addition to the katatonia. Instead of the bulk/

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bulk of stupors being called melancholic as in Clouston's time, they were called katatonic, but in both cases the prognosis was left open. Clouston apparently refused any indication of what prognosis was to be expected unless the case conformed strictly to the anergic group which is described as "a very curable form"; but Kirby's views on what features of the stupor reaction are important for prognosis have something in common with Clouston's distinctions between the anergic and the melancholic. Kirby holds that when the psychosis is expressed exclusively or chiefly in an acute stuporous reaction, the prognosis is good. In the unfavourable cases, the catatonic signs are in the beginning most often of the nature of odd behaviour, grimacing and stereotopies, followed by the gradual establishment of a stuporous condition of negativism and fixed postures. His paper was supported by Henderson, ^(a) who reported a number of cases where catatonic psychoses were shown to run a favourable course, and who disposed of the idea that "confusion" was necessarily of bad prognosis and was of any value as a prognostic criterion.

Hoch, like Kraepelin, attempted to introduce more clear-cut prognostic conceptions. He quotes Hayes Newington at length and makes this statement:-

"If one compares these data with those given in the chapter on Malignant Stupors, it is seen that in the main Newington has made the same discrimination/

"discrimination as we have".

He equates Newington's anergic group with his own benign group, and Newington's delusional with his own malignant group. Had Hoch followed these groups of Hayes Newington more closely, his work would not have been discredited as it is to-day, for the favourable prognosis in the anergic group of Newington is a much less assailable feature than the favourable prognosis in the benign stupors of Hoch. He does not mention that Newington's delusional group was subtitled "melancholic type", but is aware that Clouston used the term melancholic in the same way that Newington used the term delusional. He does not mention that Clouston held this type to be by far the most frequent form of stupor, nor does he appreciate that the four cases that Clouston reports as melancholic, to which form he attributes a fifty per cent recovery rate, are so similar to his own depressive stupors of which, he holds, a hundred per cent recover. Referring to Hayes Newington he says:- "He is certainly wrong in denying "negativism" to his anergic type"; apparently indifferent to the fact that the word anergic was chosen because it meant inactive, and that absence of negativism is ^{among} the most important of the physical findings in the anergic group, just as absence of cerebration is the most important feature on mental examination. Had Hoch denied negativism to/

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to his benign group, the follow-up might have showed a result in greater conformity with his predictions. (84)

Lewis refuses to regard stupor as a manic-depressive entity. In his paper "Melancholia: A Clinical Survey of Depressive States",⁽¹²⁾ no cases of stupor are included. "It must be clearly stated", he writes, "that in not a single case was there complete immobility and apparent failure to respond to external stimuli, such as one sees in catatonic stupor. Some of these patients were, for a time, absolutely mute, had to be fed by hand or through a tube, but they were not, except on isolated single occasions, incontinent of faeces or urine, nor did they at any time show a complete failure to respond to their surroundings, even though the response was minimal. Drug produced conditions are of course excluded. In looking through the case records of these not included in this series, who had been regarded at some time as depressive and who had been quite stuporose, one found in each of the cases evidence of schizophrenia (which had been sufficiently strong to exclude the case from the present study)". In his depressive cases he finds neither apathy nor preoccupation with death. He emphasizes that the extreme retardation of depression is not to be called stupor, and that what he finds in depressive cases is in accordance with Strecker's views: "Stupor of retarded depression. Befogged consciousness, motor inactivity/

"inactivity, scanty ideational productivity. There is not emotional apathy but often acute mental suffering". He supports Bleuler: "Melancholia attonita, as it was formerly called, is usually a catatonia with or without depression." This was Clouston's melancholic stupor and Hayes Newington's Delusional Stupor. In introducing the subject of melancholic stupor, Clouston⁽⁷⁾ says: "It is the melancholia attonita, or the melancholic avec stupeur" of the authors. To Lewis, Clouston's melancholic stupor is therefore a catatonic type of reaction in the same class as Hoch's benign stupors.

Although he includes cases of stupor in the affective reaction types, Henderson⁽¹¹⁾ emphasises the practical impossibility of clinical distinction between the depressive and the catatonic. "The stupor reaction is particularly difficult to differentiate. Symptomatically there is no way by which a depressive stupor can be differentiated from a catatonic stupor. Hoch drew up a more or less arbitrary series of criteria by which it might be possible to effect a distinction, but in actual practice such criteria do not hold good".

This expression of the difficulty that arises in diagnosis between the benign and the malignant, the manic-depressive and the schizophrenic, could not be more clearly put.

With regard to this same question of prognosis in/

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in stupor, Clouston adopted a very similar attitude.

Since his melancholic group included both benign and malignant cases, he did not require to attempt a differentiation to the same extent, but a differential diagnosis was necessary for him between "secondary stupor" and "secondary dementia". He illustrates the difficulty as follows:-

"I was taught a great lesson by the case of a young woman, aged 17, whose mother had been a patient of mine suffering from curable melancholia, who had passed through a sharp attack of acute mania of six months' duration which ran into the usual characters of dementia with dirty habits and mental lowering and degradation. I thought her so good a case of the disease that I demonstrated in her the characters of early secondary dementia to my class, giving an absolutely bad prognosis, and yet she in the long run made a good recovery and has for seven years since earned her own livelihood and is well to-day".

The same situation might easily occur to-day in relation to catatonia and depressive stupor as Clouston found in relation to secondary dementia and secondary stupor. In the intervening fifty years the bulk of the cases of the stupor reaction have twice been differentiated on a prognostic basis being first brought into the dementia praecox group, and later brought into the manic-depressive group. The present trend is more in line with Clouston, who did not differentiate between the benign and the malignant in his melancholic group, or with Kirby, who emphasised/

emphasised discrimination in prognosis, at the same time retaining the term catatonia for both the benign and the malignant.

In view of this historical record, it is not surprising that the position at present is one of some uncertainty and confusion. Henderson repeatedly points out the difficulty in a differential diagnosis, but insists on the differentiation between the catatonic and the depressive which he speaks of as equivalent to benign and malignant. This differentiation is based on pre-psychotic trends:⁽¹⁵⁾ "Symptomatically we have not been able to discover any method by which we can distinguish a benign from a malignant stupor; these which appear benign may later develop malignant and deteriorative qualities; these which seem malignant may make excellent recoveries. An analysis of the pre-psychotic personality is the safest guide."

Henderson and Gillespie⁽¹⁶⁾ state the position in similar terms:- "It is extremely difficult to differentiate clinically the various types of stupor. The stupor of the manic-depressive may be in clinical appearance identical with catatonic stupor and the stupor which one sees so frequently in toxic-exhaustive states. Hoch has attempted to differentiate between benign and more malignant forms, but his work, although suggestive, helps very little in the practical differentiation. The cases on which his views are based are not to us very convincing. Here again, the most useful guide is the history of onset, and the personality of the individual."

Henderson returns to the same point:⁽¹⁷⁾ "The depressive/

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"depressive stupor sinks into just as deep and profound an inhibition as the catatonic. In such cases the differentiation has to be effected on the basis of the pre-psychotic traits previously mentioned." The pre-psychotic traits previously mentioned refer to the manic-depressive psychosis and to schizophrenia generally. They are as follows:-

1. Manic depressive parents tend to have manic depressive children, and it is rare and unusual to have a mixture of manic-depressive and schizophrenic elements in the same sibling group.

2. "From the point of view of personality, we have a very useful guide in helping us to come to a correct interpretation of our cases. The manic-depressive or cyclothymic personality contrasts sharply with the shut-in schizophrenic. There are, of course, many cases where the less well exteriorised manic-depressive may merge into the less shut-in schizophrenic, but carefully recorded personality studies, preferably from a variety of sources, are usually very safe guides, safer almost than anything else. The rigid, gloomy, serious-minded conservative involutional type is also distinctive."

3. The presence of a pyknic type of physique can be used as additional evidence of a manic-depressive constitution.

There can be no doubt of the extreme importance of these guides. They represent the twentieth century's contribution to psychiatry. With regard to heredity it may be that the most important single factor/

factor to study is not the record of psychoses in the ancestors or collaterals, but an examination of the two parents as they present themselves. This is a study that Sullivan commends to the researcher's attention in one of his papers.

With regard to physical habitus, Henderson suggests that the criteria in this field are not so well founded as in the studies of the heredity and the type of personality. A great deal of attention has been paid to the type of personality, having regard to the cyclothymic and schizoid types. There are also, however, other factors such as the quality of character, the psychosexual maturity judged on an adolescent basis, as well as the type of character on the basis of the relative strength of pregenital fixations. Sullivan⁽⁴⁾ makes the point of the better prognosis to be expected where the oral fixations are stronger in contrast to the less favourable prognosis in anal types. This may quite well, of course, correlate with the relative prominence of extraverted and introverted traits. It would seem, however, that the type of personality, heretofore emphasised, may not be the whole sum and substance of pre-psychotic character study, and that basing diagnosis on pre-psychotic types is in the nature of employing a somewhat speculative, and rather immaturely developed characterology. Mention of but one attribute of character, namely a sense of humour, is sufficient to judge the inadequacy of criteria/

criteria of personality traits for clinical application. A mature sense of humour may have much to do with a good balance of forces in character, but its position with regard to the extraverted and introverted types is not clear.

In view of the generally accepted difficulty in the prognosis of cases of stupor, however, there can be no quarrel with the method of tentatively basing a prognosis on a pre-psychotic history. But to base a diagnosis on a pre-psychotic history presents two difficulties. Firstly, the diagnosis is come to on the assumption of a good or bad prognosis, and an alteration in diagnosis becomes necessary should the very tentative prognostic assumption prove false. Secondly, the rigid system of division of psychoses into those of good and those of bad prognosis is retained, although it is freely admitted that such prognosis may be so tentative as to border on the speculative.

It would seem better to name depressive and catatonic stupors by the same name, to assess prognosis in individual cases by the pre-psychotic history, and possibly to differentiate different types of stupors on clinical grounds, if this seem feasible, the important thing being that in the first instance a name can be given to a patient without/

without its being a prognostic verdict.

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Lewis excludes stupors from his survey and considers that they should be regarded as belonging to the katatonic group of schizophrenics. There would then be no necessity for a vertical diagnostic and prognostic division within the stupor group. The line is drawn between the retarded depression and the stupor, rather than between one kind of stupor and another. Lewis claims that there is little difficulty in differentiating the extremely retarded depression from the stupor. Whether it is as easy as Lewis suggests, there would no doubt be a consensus of opinion in favour of its being easier than the differentiation of one kind of stupor from another. To have stupors as a group within the schizophrenic denomination would do no violence to the greater part of the conceptions with regard to this group prior to the publication of Hoch's book, emancipated as we are from any rigid prognostic verdict in schizophrenia and particularly in katatonia by the work of Meyer, Kirby and Henderson.

There are three reasons why this course should not be taken, and they are of doubtful validity. The first is the traditional conception of the depressive melancholic stupor; the second is represented by Hoch's thesis and arguments; the third is the occurrence of stupor in recurrent form and associated in some cases in the same patient with/

with attacks of depression and mania. With regard to the first difficulty, there is the use of the term melancholic stupor by Clouston which he says is the same condition as "melancholia attonita". We have already seen that Lewis quotes Bleuler to the effect that melancholia attonita is usually a katatonia with or without depression. It should be remembered also that Clouston's melancholic is the same as Hayes Newington's delusional group, and that Clouston regards it as quite separate from melancholia itself and gives it a separate differentiation on symptomatic grounds as shown in the beginning of his chapter: ⁽⁷⁾ "You will not find stupor put among the ordinary symptomatological varieties of mental diseases, along with mania, melancholia, etc. This, I think, is a mistake." Much of Clouston's mania and melancholia, incidentally, would now be regarded as schizophrenia. His prognosis in these groups is only a fifty per cent recovery rate, ⁽¹⁾ and thirty percent of the population of his hospital consisted of cases of secondary dementia following on attacks of mania, ⁽¹⁴⁾ these being cases of adolescent insanity.

With regard to Hoch's thesis and arguments, much criticism has already been cited. According to McCurdy ⁽¹⁸⁾ it was his ambition to prove that although elation and depression were the commonest mood anomalies in the manic-depressive group, they had no more theoretic importance than anxiety, distressed perplexity/

perplexity and apathy - apathy, though less frequent, being just as characteristic a mood change in the manic-depressive psychosis as elation and depression. This appears to be the psychological basis for the differentiation of Hoch's groups and the inclusion of the benign stupor in the manic depressive group, just as the good prognosis that was expected was the main reason for their psychiatric classification. Without understanding depression, we can say that we are familiar with its widespread occurrence, as we are with the occurrence of elation, and that are both capable of description, whether by the man in the street or in the finer terms of Euripides, Shakespeare, or Coleridge. Apathy,^{as} assumed to be present in the stupor reaction, would appear to be more difficult to describe however, whether from subjective experience or objective evaluation. A clinical picture characterised mainly by an appearance of apathy would come nearer to meeting Lewis's first criterion of what constitutes schizophrenic features⁽¹²⁾ - "disorders of thought or of conduct into which it was impossible for the observer to enter except by an intellectual process, rather than from understanding through comparable experience".

The other main signs of Hoch's benign stupor reaction - inactivity, negativism and interference with the intellectual processes - may occur in many/

many psychotic conditions. Where the presenting signs are of a more regressive quality than in the usual manic-depressive cases, and where depression and elation are not so prominent, it would seem better to include the cases with others of a similarly regressive nature.

Further, the grouping of cases of stupor along with cases of uncertain prognosis would seem to have some justification on grounds of ascertained outcome, as well as on a study of the clinical facts. Hoch's cases were gathered together with recovery as the main criterion, but a follow-up of his cases which has recently been reported would seem to indicate that his views with regard to their further course have not been well founded. On account of the difficulties of differential diagnosis, doubts as to the psychological status of the state of apparent apathy, and the follow-up that has been made, there would seem to be some justification for discontinuing the use of the term manic-depressive stupor. On the one hand we would then avoid having to change the diagnosis after the outcome, for the less emphasis that is laid on probable outcome in the diagnosis, the less likely is that diagnosis to be affected by a subsequent examination. On the other hand a diagnosis could be made on the clinical picture as it presents itself rather than on what is necessarily a rather arbitrary estimate of the pre-psychotic/

pre-psychotic history, which is in effect a diagnosis by probable outcome, the reasoning being that if the patient has been well adapted he will probably recover and is therefore considered manic-depressive. This leaves the clinician open to Meyer's strictures on the practice of "sorting out the patients instead of the facts".

With regard to the difficulty presented by the fact that stupor occurs in recurrent form or in association with attacks of mania and melancholia, there would seem to be no reason why a nomenclature similar to that of Kirby's paper should not be retained, for he included them under the term catatonia. The prognosis is good in proportion to any manic-depressive feature present or in relation to the cyclothymic features in the pre-psychotic history as Henderson clearly states.

A further difficulty may be suggested by the fact that, although the process may be so regressive as to warrant the use of the term schizophrenia, the delusions at the outset may be of a distinctly depressive type. The fact, however, should be remembered that most cases of psychosis in young people begin with depressive thoughts.

If the stupor is regarded as within the schizophrenic classification, or in a group "allied to schizophrenia", there may still be a differentiation between those where the delusions and accompanying emotional tone is depressive, and "manic stupor", where/

where the delusions are of a more exalted type, just as paranoia is referred to as being depressive or hypochondriacal and exalted. Possibly the term stupor with exalted ideas, is better than the contradiction manic stupor.

Hoch's work has been criticised, but his observations were not inaccurate, and it is worth while to enquire why it is so much the fashion to criticise his work. No doubt the most important single fact is that his differentiation was so closely linked up with a prognosis which was not proved right by the follow-up. The criticisms by Henderson and Gillespie, however, were made before the publication of the follow-up results. The reason would appear to be that the true relation between depression and recovery, and schizophrenia and dementia was carried into the intermediate noman's land of the stupors with misleading results. The method at present advocated can be followed only if schizophrenia is stripped of its prognostic significance. Psychotic stupors occur with amazingly quick and complete recoveries. Are these to be included within the schizophrenic denomination? It will be pointed out later that one of the compelling reasons for that inclusion is that it is sometimes the cases with least evidence of affect that recover quickest, the cases in which the regression or dissociation is most wholesale and complete, and free from complicating emotions - the anergic condition.

HISTORICAL SURVEY WITH REFERENCE TO THE RECOVERY
OF CASES OF SCHIZOPHRENIA OTHER THAN CATATONIA.

We have seen that the reaction against the prognostic classification in relation to schizophrenia which Meyer encouraged went to such an extreme that the majority of cases of stupor came to be included in the manic depressive group. The lead that Meyer gave in encouraging the evolution of ideas with regard to prognosis was not followed so quickly in the application to other forms of schizophrenia than the catatonic. From about the time of the publication of Hoch's book, however, recovered cases of schizophrenia, other than catatonia, have been frequently reported. They are all valuable reports, but the most famous paper, that of Edward Strecker⁽⁴⁾, shows the same unfortunate tendency as is present in Hoch's work, namely, to bring the recovered cases nearer to the manic depressive group if not, as in Hoch's cases, actually within it. We prefer Kirby's attitude and the present study emphasises the importance of extending to the whole field of schizophrenia, the prognostic principles which Kirby formulated in relation to the catatonic group. Such a study is in the nature of a further attempt to justify Meyer's views on prognosis. A review of contributions already made on these lines is here reported. They refer to cases diagnosed as schizophrenia/

schizophrenia, for the most part other than catatonia, where recovery has taken place..

In 1918, Henderson⁽¹⁷⁾ reported a series of war cases including five cases of dementia praecox, or of a dementia praecox type, with recovery, illustrating the kind of adjustment that these patients so frequently made. The schizophrenic reactions had been mainly of a paranoid type. Two further cases of war patients, also of the paranoid type of schizophrenia, who made adequate recoveries are reported by Henderson and Gillespie.

Theodore Hoch, in 1922⁽¹⁸⁾, reported seven cases of acute psychoses with symptoms resembling dementia praecox and subsequent recovery.

Menninger,⁽¹⁹⁾ in 1922, made a study of a series of cases of post-influenzal psychoses of a schizophrenic type. Three of these were young people with recovery, and in a fourth case the recovery was/

was not regarded as complete. Both hallucinosis and manic-like features played a large part in these illnesses.

In 1924, Strecker and Willey⁽¹⁹⁾ reported twenty-five cases under the heading - "An Analysis of Recoverable Dementia Praecox Reactions." These were taken from a series of 187 cases of dementia praecox so that the series showed a recovery rate of 13.3%. The average duration of the known period of recovery was over five years. These cases are again referred to in 1927⁽³¹⁾ when thirty-eight recovered cases are referred to, but the additional cases are not reported. There is also reference to them in 1929⁽³²⁾ when six are reported as being at a better level of adjustment than that obtaining before the onset of the psychosis.

Strecker and Willey do not make any attempt to suggest any further grouping of their cases, but there is evident in them a great variety of reaction types. The ages of onset vary from 19 to 43, and in symptomatology they include cases with depressive tone accompanied by ideas of reference which are sufficiently prominent for the schizophrenic features to be considered dominant, as well as cases showing considerable sensorial defect, and stupor reactions of some years duration. With regard to two cases, the differential diagnosis of depression and schizophrenia is discussed, the patients/

patients showing ideas of reference and depression. The ages of these patients is 29 and 30. In seven cases, ranging in age from 19 to 40, the most prominent features would appear to be ideas of reference and delusions of persecution of a changeable kind. Three cases, aged 29, 31 and 33 had hallucinatory experiences involving contact with the supernatural, accompanied by hypomanic behaviour. In eleven cases, ranging in age from 19 to 28, the reaction appeared to be mainly of a catatonic nature. In two cases of women aged 40 and 43, both catatonic and confusional features are described, one being a case of puerperal insanity.

The cases where the catatonic symptoms were more prominent, were shorter in the duration of the psychosis than the predominantly paranoid, the psychosis lasting about a year in the latter and about six months in the former. The paranoid group were from a better social and educational level with fewer foreigners among them, but the pre-psychotic history showed more morbid trends.

In 1925, Gordon reported seven cases of prolonged confusional states simulating dementia praecox. In six of these cases physical ill-health contributed to the onset of the psychosis - lobar pneumonia, broncho-pneumonia, child-birth, haemorrhage/

haemorrhage in a haemophilic, and a spell of unaccustomed severe physical exertion. The duration of the psychoses was from six months to two and a half years. These cases bear a resemblance to the cases reported by Kirby, Hoch⁽¹⁴⁾ and MacCurdy⁽¹⁵⁾ in the group of perplexity states.

Macfie Campbell⁽²⁴⁾, in 1926, reported two cases showing a combination of affective and schizophrenic symptoms. One of these cases was a woman of 29 in her sixth attack of illness, which took the form of a retarded depression with simple ideas of reference. One of the previous attacks, at the age of 21, was characterised by an initial period of depression, with reference to her mind being read, followed by variable mood with impulsive boisterous behaviour; over-active - auto-erotic - exposing herself - talkativeness alternating with refusal to answer; content of thought occupied by religious ideas. The diagnosis was catatonic dementia praecox.

Skottowe⁽²⁶⁾ reports a case in 1930 of a psychosis of eight and a half months' duration, characterised at one stage by grimacing, giggling, lack of responsiveness and lack of co-operation, hallucinosis and impulsiveness. She was regarded as showing "a true splitting or dissociation of the psychic functions - a temporary disintegration", and the diagnosis was that of schizophrenia.

In 1931,⁽¹⁷⁾ Lewis and Blanchard reported 100 cases of schizophrenia which had recovered. The pre-psychotic adjustment had in most cases been inadequate and recovery from the psychosis had been incomplete. The cases are reported as a group and the symptoms tabulated, but none are reported individually.

Mention should be made of two recent reports on groups of cases which might fall within the recoverable schizophrenic group. The writers, apparently giving up hope of seeing the old terms stripped of prognostic meaning, have abandoned their use in favour of terms with no such significance. If this is an advance, it is also an admission of defeat. An attempt is made to take the cases of more favourable prognosis right out of the schizophrenic group, although Hoch's example is not followed in their being put into the manic depressive group. They are referred to as Schizo-Affective Psychoses,⁽¹⁸⁾ and Psychoses Midway⁽¹⁹⁾ between Schizophrenia and Manic Depressive Psychosis.

Reported Cases Diagnosed as
Midway between Schizophrenia
and Manic-Depressive Psychosis.

(18)
In 1933, Kasanin described a series of cases under the heading of - "The Acute Schizo-Affective Psychoses". Five of these cases are fully reported. In four there is an experience of mystic relationship with the supernatural, with prominent hallucinosis, the predominant mood being elation. In the other case there were ideas of reference, delusions of persecution with hallucinosis, the predominant affective response being apparently one of fearful anxiety associated with the persecutory trends.

The study of schizo-affective psychoses has been taken a step further by the report in 1936 by Hunt and Appel⁽²⁴⁾ of thirty cases "which were undiagnosed because of the even mixture of schizophrenic and manic-depressive features". The report deals with the course that these cases followed.

Discussion on the Reported Cases

The views of the various writers on the cases of recovered schizophrenia that they reported have now to be considered. Since there was a general assumption that there was an inherent close association between the essential features of schizophrenia and the progress to dementia, the recovery of cases of schizophrenia presented a certain difficulty. Various attempts were made to separate these recoverable cases into groups which did not reveal the more essentially schizophrenic characters. In the earlier discussions, such as Kirby's discussion on catatonia and Henderson's paper on the same subject, various points are referred to which might affect the prognosis, but no attempt was made to make a separation of the recoverable from the non-recoverable cases. Hoch's book on Benign Stupors represents such an attempt. A report is given here of various similar attempts which have been made since the publication of Hoch's book. In no case is Hoch's boldness followed in frankly calling the recovered cases manic depressive, but all put forward tentative suggestions in favour of differentiating the recoverable patients more or less within the schizophrenic classification.

Macfie Campbell⁽³⁰⁾ has said that the schizophrenic group is an extraordinarily wide group; that, with regard/

regard to it, there is a great deal of diversity of opinion, and that it was very important, in trying to make any progress in regard to these cases, to take up various sub-groups which had if possible some homogeneity. Kasanin, in discussing the Kraepelinian classifications, considered that these groups were so general and contain such a large number of heterogeneous cases with different clinical pictures, that it was no wonder that the experimental results were quite worthless; and, he adds - "I doubt very much if experimental research in psychiatry will ever yield any results unless we deal with fairly homogeneous groups."

Those who have reported the cases which have been reviewed have suggested delineations of such groups, and an attempt will be made to see how much there is in common in the groups that the various authors have delineated. The methods of grouping have this in common - that all are attempts to correlate the features of the psychosis with the course/

course of the illness. In most, a correlation with pre-psychotic development has also been stressed.

Kasanin⁽¹³⁾ distinguishes between 'nuclear' cases, and 'schizo-affective' cases, as follows:-

"With regard to the nuclear cases, it is our duty to find them so that they may be a basis for special clinical entities. I think we are pretty certain of constitutional schizophrenics who show a good deal of physical difficulty in infancy, a stormy childhood with over-protection and anxiety, a difficult adolescence, especially characterised by inability to get along and mix with other children, and, finally, the breakdown."

"It is for this reason", Kasanin goes on, "that I have selected the group of schizo-affective psychoses which is the other extreme from the nuclear constitutional cases." He found that his patients who developed schizo-affective states were introverted when considered on a subjective review, but considered objectively they were "fairly young individuals, quite well integrated socially, who suddenly blow up into a dramatic psychosis and present a clinical picture which may be called either affective or schizophrenic, and in which the differential diagnosis is extremely difficult."

Strecker and Willey⁽¹⁴⁾ distinguish between "basic/

"basic and constitutional cases", and "cases susceptible to explanation which revealed the disease process as other than basic and constitutional":-

"As the resume of our studies is presented it will be noted that perhaps they have succeeded in partially defining a class of patient clinically rather typically schizophrenic, but on analysis either in themselves or in their psychosis, susceptible to explanations which revealed the disease process as other than basic and constitutional".

By "susceptible to analysis" it is understood that the illness is capable of explanation on the basis of the withdrawal representing a logical defence on the part of the patient, or being determined by pre-psychotic idiosyncrasies. A distinction is drawn between shut-in types where the withdrawal could be considered as constitutionally determined, and shut-in types where such withdrawal could be considered a natural reaction on account of early upbringing or later environment.

(33)
Sullivan distinguishes between cases of insidious onset where there is the possibility of "an organic substratum of the personality" and cases of "young acute schizophrenics". His remarks on cases of insidious onset may be quoted:-
"I/

"I can only take this opportunity of emphasising again the great prognostic importance of insidious onset where the individual has very gradually gotten eccentric and become far different from his previous personality, before conspicuous phenomena pointed to his being psychotic. That patient, so far as I know, is in a very bad way".

His attitude to cases of young acute schizophrenics is quoted for contrast:- "...there is no great importance to be attached to the organic substratum of personality in young acute schizophrenics, but rather great stress to be laid on the socio-psychiatric treatment to which they are exposed in our studying of the factors relevant to outcome".

His tentative delineation of the two groups is further set forth:- "The acuteness or insidiousness of onset of the observed psychosis, however, may finally give the question of the underlying organic state new relevance. It is quite possible that an ultimately measurable something of great prognostic significance may be found to underlie these insidious disintegrations of personality, attended by more or less schizophrenic phenomena, that are now lumped with disorders of acute observed onset. Statistics of the Sheppard experience indicate so great a difference in course of these two groups, that one cannot but wish that effort might be directed to a comparative study of individuals/

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individuals of acute versus insidious observed onset".

Menninger,⁽²⁾ in 1922, recognised cases of schizophrenia that recovered. He emphasised that such cases were indistinguishable in cross section from the classical picture of schizophrenia, and made a strong plea for laying aside an assumed technique of discrimination between the two. From a study of cases of schizophrenia associated with influenza, he classified schizophrenia in three groups - those showing ultimate, irrevocable, total dementia; acute manifestations in waves or attacks (much after the classical fashion of manic-depressive psychosis); and cases presenting the syndrome of schizophrenia, but arising from variously constructed soils and making what is apparently a complete and permanent recovery. He states his conclusion that there is a progressive gradation between the mildest attack of simple delirium and the most profound dementia of late schizophrenia, in the degree of reversibility, the potentiality of recovery.

Regarding schizophrenia as a somato-psychosis, as the psychic manifestations of an encephalitis, Menninger makes a classification which has this in common with Kraepelin's method, that, in Meyer's words, it "seems to despair of the possibility of a causal analysis and merely puts down the formal results"./

results".

Leaving no room for correlating the psychosis and the prognosis with the features of the pre-psychosis, he considers the reversibility to depend on the unknown quantity of the relative malignancy of the presumed encephalitis. His classification, however, is so far corroborative of the experience of others who have attempted to group cases of schizophrenia, in that it gives prominence to the gross variability in course found in different cases. It is, however, a diagnosis, or grouping, by outcome. He describes the syndrome, and then pigeon-holes the cases according to the result.

Bleuler's⁽³⁴⁾ division into two groups also subsumes a knowledge of aetiology. His classification is into physiogenic and psychogenic types. In the physiogenic type there is involved a "pre-disposition of the brain of the nature of a progressive disease". Psychic factors have their place in shaping delusional systems and in inducing withdrawal from reality, but these features are not of a schizophrenic nature without the particular predisposition explicable on physiogenic grounds. On the whole he regarded schizophrenia as a physical disease with a lingering course, but clearly also states that there are catatonic spells of a purely physical and others of a purely psychogenic/

psychogenic nature. The respective prognoses of the psychogenic and physiogenic states he regards in the following terms:-

"Theoretically, reactions have to be separated from the episodes, although both forms of exacerbation are in practice not always easily distinguishable from each other and are prone to mix, but if they are really only psychogenic, they can heal to the earlier state; real deterioration is in connection with the physiogenic process. The prognosis of the psychogenic-physiogenic mixing is dependent on it, however important each of the two components may be in the picture, and then on the unfortunately incalculable capacity for involution of the physiogenic part."

It would appear that the more fixed the ideas are with regard to aetiology, then the more incalculable becomes the prognosis. Bleuler's conception, however, conforms with the conclusions of the other authorities already given in that it reveals a clinical experience of two distinct courses that schizophrenia may follow.

A reading of his paper gives the further impression, that the illnesses of shorter course - called psychogenic - are more abrupt in onset and more dependent on precipitating environmental factors.

(35)
Strauss, giving the views of a German school, believes/

believes that the states already described as being other than "nuclear", or "basic and constitutional", should be withdrawn from the schizophrenic classification. Acknowledging that "there are a number of conditions which exhibit schizophrenic symptoms", chief amongst these being "certain forms of the psychosis of puberty and situational schizophrenia-like attacks", he considers that such states should not be grouped among the true varieties of schizophrenia. Contrasted with these states he considers "schizophrenia of the true endogenous type", and his paper is concerned with the question of prognostic criteria in the cases considered endogenous, which cases, in common with Bleuler, he regards as being associated with a progressive disease process.

The present study is concerned with these types which Strauss excludes from the true delineation of the schizophrenic classification. In spite of gross variations in point of view with regard to the nature of schizophrenia, there is a remarkable similarity in the way in which these cases are described by different writers. These psychoses are referred to by Bleuler as being precipitated mainly by psychogenic causes, by Menninger, (on a prognostic classification), as being reversible, by Strecker as being capable of explanation in terms of a natural reaction to environment/

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environment, by Sullivan as being of acute onset,
and by Kasanin as being schizo-affective.

The cases have usually been reported with a
view to their being distinguished from the more
malignant forms of schizophrenia, which by contrast
have been termed variously - nuclear, basic and
constitutional, insidiously developing, irreversible,
physiogenic, endogenous.

In all these attempts to divide the schizo-
phrenic group there may not be much added to the
Meyerian division into schizophrenia and schizo-
phrenic-like.

A Discussion on the Naming of Cases of
a Schizophrenic Nature in the Light of the Fore-
:going Historical Survey.



A discussion of the opinions of the writers who have been quoted, would amount to a discussion on the alternative methods of naming cases of doubtful prognosis. It is here recommended that, rather than excluding all hopeful cases from the schizophrenic group, the term should be stripped of any necessary association with malignancy and should be applied in a wide descriptive, rather than a narrow prognostic, basis.

One thing is clear from this historical survey, and that is this, that in the discussion of prognosis in relation to the cases presented, it is not necessary to be hampered by a restricting nomenclature. It is necessary to have a diagnosis and to examine the aetiological factors and to give an estimate of prognosis, but a historical review makes it clear that so long as we use descriptive terms on a symptomatic basis, the less emphatically the terms are used, the more useful they are. If the use of diagnostic terms have been laboured, it is because these terms tend to present an encumbrance that has to be negotiated, before a more dynamic attitude can be assumed. It is good to be on the watch for progressive ideas and we await the evolution of an authoritative pathology for the psychoses. Meanwhile, if our terms are/

are descriptive, let them be no more than descriptive and let them not assume, by inference, an unknown pathology of some kind, as many psychiatrists are tempted to accord to the term schizophrenia. A pathology may make all things clear, but with regard to prognosis there is very little that is quite clear at the present time. We may perhaps be permitted this short discussion on the use of terms and we will then have done with them and be free to take the individual cases in relation to the questions put in our first few pages. The question that will occur in the discussion of each case is this: will the patient tend to strengthen in his recovery and to increase in stability, or will he relapse or continue unstable, or become progressively involved in the psychosis? If the patient does in fact deteriorate, it would be difficult but to suggest that it has turned out that he has been "schizophrenic" all the time. Such a remark would indicate that there is a persistent use of the term "schizophrenia" to sum up all that is malignant. In spite of thirty years of criticism of prognostic terminology, it would appear that, apart from malignancy, schizophrenia has little meaning, as a term. If a description of schizophrenia is given, could not the description apply/

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apply equally well to dementia? There is no doubt that in the minds of most psychiatrists, malignant implications remain with the term. Strecker⁽¹⁹⁾, for example, although he is reporting cases of schizophrenia which have recovered, shows no sign of using the term without a prognostic significance. He is constantly endeavouring to discover characteristics of his patients, or of their psychoses, which, if discovered earlier, might have saved the patients from being called schizophrenic. Since he is reporting cases of recovered schizophrenia, and since he holds to the use of the term to sum up all that is malignant, he comes very near to contradicting himself. He holds that the value of a prognostic research lies chiefly in its ability to uncover dementia praecox reactions, or, if preferred, praecox-like reactions, which are recovered from, and to discover how, and to what extent, they differ from these types which eventuate in chronicity. With regard to true schizophrenia, however, he thinks that "absolute accuracy of diagnosis" depends on "deterioration of sufficiently long duration and of such gross type that chronicity and malignancy are expressed in the unmistakable character of the true dementia." He is saved by the use of the term "praecox-like," as distinguished/

distinguished from the malignant variety of praecox reaction. This is still diagnosis by outcome. If a case of schizophrenia recovers, it was not a case of schizophrenia - it was "praecox-like." Bleuler has a similar attitude to the relationship between schizophrenia and malignancy. Kasanin⁽¹⁶⁾ quotes him as saying, "... only prolonged observation would lead to a correct diagnosis, with hallucinations and deterioration as the ultimate criterion." This is prognostic classification, pure and simple, although it should be added that in 1930 Bleuler⁽¹⁴⁾ indicated that to speak in terms of recovery was not out of place in the consideration of certain kinds of schizophrenia.

Although Myer so frequently advocates the separation of diagnostic and prognostic considerations, it would not appear, from a reading of his paper published in 1922, that he regards the distinctively schizophrenic and the prognostically ominous as one and the same thing: ⁽⁵⁾ "The closer we come towards "autistic thinking, projection and more or less leading "hallucinations, without adequate excuse by affect or "without dysergastic disorder, the more likely "do we deal with schizophrenic reaction..... The "greater the incongruity of affect and content, and the "consequent/

"consequent distortion, the more ominous the condition."

If schizophrenia is not used to sum up all malignant tendencies, what does the word mean? Sullivan⁽⁴¹⁾ is an outstanding exception to most writers, in that he draws a clear distinction between what is essentially schizophrenic and what is essentially malignant. He holds that the outstanding example in making the difference is in consideration of catatonia, in which condition he believes purely schizophrenic dissociation may be greater than in the more malignant forms.

If we sum up the views of the writers that have been referred to, three alternatives in the use of the term schizophrenia, can be recognised. The use of the term in a fourth commonly accepted sense is added.

Firstly, it can be used to describe the essentially malignant reactions and no others. This is the use advocated by E. B. Strauss⁽⁴²⁾ in his description of the methods in use in Kretschmer's clinic at Marburg.

Secondly, the term can be used for the most part to indicate malignancy, but modifications can be made. Bleuler⁽⁴³⁾, for example, holds that to speak in terms of recovery is not out of place in the consideration of certain kinds of schizophrenia. Similarly, Strecker⁽⁴⁴⁾ would seem to indicate that true schizophrenia is malignant/

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malignant, but praecox-like reactions are not necessarily so.

Thirdly, the term can be used as by Sullivan, to indicate a process, a kind of dissociation, something quite apart from a disease with a malignant cause.

Fourthly, the term can be used on a symptomatic-ally descriptive basis. This would amount to the use of the term schizophrenic, as synonymous with the term regressive.

A further alternative is to abandon the use of the term, in favour of the use of more correctly symptomatically descriptive terms, such as katatonic reaction, stupor reaction, paraphrenic reaction, paranoid reaction, dementia.

As a prognostic classification is out of Court, we are confined to the third, fourth or fifth of these alternatives. The usual practice, among those who do not think prognostically, is to mix the third and fourth. A reading of all Sullivan's papers may be thought by some to be sufficiently convincing of the impracticability of the use of the term, to imply the kind of process that he envisages, in view of the involved nature of his classifications of the schizophrenic process. This may, of course, be to neglect what is difficult to understand. Sullivan⁽³⁸⁾ describes/

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describes his attitude to the schizophrenic process
(40)
as follows: "Schizophrenia is regarded by the writer
"as a term to be applied to a large and variegated
"group of life processes, showing as characteristics,
"(a) regressive preponderance in implicit total
"activity of fantasy as compared with the previously
"acquired - and temporarily inactive - externally
"controlled thought processes;
"(b) a regressive preponderance of overt total activity
"of the type of irrational, ritualistic and magical
"behaviour; and
"(c) an underlying extraordinary preponderance of
"certain motivation, normally accorded by occasional
"expression in life."

Five years earlier he had stated his view rather
more simply: (5)
"The mental structure is dissociated
"in such fashion that the disintegrated portions regress
"in function to earlier levels of mental ontology,
"without parallelism in individual depth of regression.
"This disparity in depth seems the essence of that which
"is schizophrenic, as distinct from other mental
"disorders." This is rather more easy to follow and
is not out of line with Meyer's (5) more descriptive
approach to the essential features of schizophrenia.

With/

th regard to the fourth alternative, has it any advantages over the fifth? If schizophrenia does not indicate malignancy, or does not define a process, is it of any value as an indication of the nature of symptoms?

Each of the last three alternatives would seem to be justifiable. The term should be available to indicate a process, for the benefit of those who are willing to study the process in the way that Sullivan does.

Secondly the term can be used to indicate a condition with prominent regressive features, preferably being applied only, on account of this being customary, to the condition as it occurs in young people.

Thirdly, this is so vague, that a gradual increase in the use of other descriptive terms should be encouraged, where these terms are justified on a descriptive basis. This would seem to be a return to a pre-Kraepelinian nomenclature, such as Clouston employed, but the attitude to cases does not depend on terminology and a descriptive terminology should be as little encumbrance as possible to the progress of ideas.

There remains the question of the use of the terms, The Schizo-Affective Psychoses⁽²⁴⁾, and Psychoses lying Midway between Schizophrenic and Manic Depressive Psychoses⁽²⁵⁾. Glover⁽²⁶⁾ suggests the possibility of a future/

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future for some such terms on a rational basis, in these remarks: "Moreover, it appears reasonable to suppose that the rigid interlocking, which hampers one system of classification, may prove to be the firm groundwork of an unknown grouping. For example, if we find a delusional element common to schizophrenia and to paranoia, or an affective system common to schizophrenia and melancholia, it is always possible that the common element should have been the main factor in the classification." The value of the terms at the present time, however, would seem to lie in the descriptive vagueness and absence of prognostic interest, rather than in their describing a distinctive process. If the term schizophrenia is used with equal vagueness and with equal prognostic freedom, these terms are not necessary.

In this paper the term schizophrenia, like all other diagnostic terms, is used on the basis of descriptive symptomatology.

If the term is not used to define a process, but only, and rather vaguely, to describe symptoms of a certain nature, then it is not necessary to discuss further the question whether the essentially malignant features are the same as the essential features of schizophrenia. If schizophrenia is regarded as a process, the study of the relation between this process and/

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and malignancy would be necessary, but it would best be done along with a series of cases, which had run, or were in the midst of, a psychosis of apparently chronic and malignant course. Sullivan has applied himself to this problem, but without a report of cases. (37, 38)

Having regard to the nature of the case material in this study, it would be better to consider those features, which would seem to indicate a favourable prognosis, to discuss the extent to which they are present and to attempt to assess how much their presence is worth.

PRESENTATION OF CASES.

FIRST GROUP.

Several cases are presented and prognostic conclusions are drawn from various features in the patients and their psychoses. The first cases that are reported here are cases of stupors. In relation to these cases, the points of prognostic interest which are particularly mentioned, have relation to the patients in the psychoses itself, and, where there has been improvement, in their subsequent attempt at adaptation. The features that have been particularly mentioned, are the effect of environment on recovery; the importance of hysterical symptoms at the onset of the psychosis and of the psychosis having a hysteroid element in it; the general question of preservation of affect; and the importance of the dynamics of a regressive process. The significance of acute onset and of an adequate precipitating situation are referred to in relation to the cases. The adequacy of the social adaptation of the individual before the onset of the psychosis is not referred to at length in this section. In view of the fact, however, that some of the cases occur at puberty and adolescence, it is pointed out that an immaturity indicates, of necessity, an inadequate adaptation and that an acute psychosis, occurring at such an early age is of more grave import for the future life of the individual, than a similar illness occurring in later years.

In two of the cases the course of the illness has been/

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been of particular interest and has been specially referred to. Beginning with a hypochondria, which in one case seemed to be of a hysterical nature, the patients developed stupor reactions, followed by hypomanic phases, which in each case were superseded by a phase of resentful antagonism, a perseverative kind of hypomanic reaction, with aggressive and destructive tendencies, and general conduct of an anti-social, rather than of an asocial nature. The significance of these changes in relation to prognosis is discussed.

The significance of the adequacy of the pre-psychotic social adaptation and the questions involved in relation to the psychosis in its origins in the interplay of individual and environmental forces, is discussed in a later section which deals with psychoses occurring in the third decade, the first section dealing, for the most part, with psychoses occurring in the second decade. In the first part it is the relation to the internal environment that assumes prominence, (the puberty situation and adolescent development). In the second, the social relationships are fully dealt with.

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The cases that are here presented have been selected on account of the problems they raise in relation to prognosis. All are cases where the prognosis is not clear and where the psychosis and its onset, the environmental circumstances and the pre-psychotic history have to be carefully assessed, if they are to form the basis of a prognostic opinion.

The first case is that of a girl, who was admitted in a condition of stupor at the age of 15. She was quite mute on admission. She was quite passive; took food that was offered to her and was put to bed without difficulty. On the following day, however, she refused food, frequently attempted to get out of bed and was restrained only with difficulty, and continued in silence. She sat up in bed with a vacant look, dribbling saliva. Tube-feeding was started and had to be continued for four days. The expression was one of surprise and unhappiness. She could be prevailed upon to eat the food that her mother brought into hospital for her, before she would resume eating ordinary food. An attack of influenza delayed her recovery. She spoke freely six weeks after admission and was discharged in four months. The following is a brief history with notes of the feelings of the patient during her illness, as recollected by her afterwards.

The patient, the oldest of five, has lived with her/

her grandmother in the country for eight years. At 13½ she got exemption from school to look after her grandmother. At 14 she went for a month to work as a domestic servant, then she was for 6 months in a fruiterer's shop, but when it came to winter she felt it cold, got congestion of the lungs, stayed at home all winter and then went to work the following summer (1936, aet. 15) for six months in a boarding-house. The present illness began there about the month of July, when she began to feel depressed, would not go out, lost her appetite and had amenorrhoea which worried her greatly. Her doctor wrote that at this time he regarded her as young for her years and rather hysterical. She came to Edinburgh, was taken to the Chalmers's Hospital and was operated on. She was then discharged to her parents' home in Edinburgh. She took food well for the first day, then went off her food and was admitted to the Jordanburn Nerve Hospital three or four days later. During that time she had nightmares. In Chalmer's Hospital, she had been afraid and in her parents' home she saw nurses moving about the room and a lot of instruments, and people opening a space in the wall, and chopping the wall with hammers and chisel. She saw the gravedigger going round, and a boat come sailing into the middle of the floor. She said that when she came to /

to hospital, she was worried, but did not know what she was worried about. They had told her at home, "If you don't go into hospital and get better, you will go into a decline." She thought she was in a decline and knew that if people got there, then they died, and this was what she thought was happening to her. Her periods did not come on and that worried her most of all. They were absent from July until January, the usual being 5/28. If the periods did not come, then the blood went to the brain and an old woman had told her not to sit over the fire with her head down, for that would make the blood go to her brain. She had tried to remain in hospital, but did not feel able. She liked seeing visitors and knew all that was going on - remembers the Christmas party a week after admission and so on. She thought she never slept. She saw the dentist, who treated her in the dental Hospital, coming in; she saw every ward in the Chalmer's Hospital and knew that the big porter was out in a corridor, waiting to take her away. In the Chalmer's Hospital, she had dreamt that she was going downstairs to a dungeon place and would never get back. There was a door onto a verandah, behind her bed and one night she felt the pillows slipping away and the bed going down into a dungeon. She heard noises like - "Going to chop your head off."

She/

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She did not feel any life in her; wanted to get well, but knew she never would. The tube-feeds sickened her at first - so much so, that she began to eat of her own accord, although she had no appetite. Her weight was 5 stone 12 lbs. in January, and 6 stones 8 lbs. in April. Her weight had probably been lower after the weighing in January, when she had influenza and was not weighed. The impression was that the patient, being brought up by her grandmother, had been rather spoiled; was a superficial, garrulous individual and had been hearing a lot of old wives' tales, and living in an unnatural atmosphere. She had had exemption from school and had been expected to grow up then. With regard to the amenorrhoea, she explained that it would be all right for a young girl, but as she was about the age of being a young woman, it assumed important proportions.

This patient had probably had an unusual outlook, dependent upon the circumstances of her up-bringing among elderly people, and though talkative, did not have a high degree of intelligence. She had a period of amenorrhoea and anorexia, and probably showed a mild degree of anorexia nervosa, based on the conviction that she was going into a consumptive decline. The circumstances, precipitating the stupor, were almost certainly the state in the Chalmer's Hospital, associated/

associated with the operative procedures (D. and C.).

When she left hospital, the patient returned to her grandmother's house. She was re-admitted to hospital six months later. She was in good mental health when she left hospital, but at home she became excitable, over-talkative and over-active. She made a habit of visiting friends in the morning and not returning till late in the afternoon. She left orders in shops without permission, often in excess of what was required. She sang loudly at home. Being beyond the control of her grandmother, she was taken to her own home, where she proved equally difficult. For hours at a time her mother would be completely unaware of her whereabouts. She ran up bills. If corrected in her behaviour, she gave way to violent screaming, which is quite foreign to her normal behaviour. On admission to hospital, she was in a state of elation, with much pressure of talk and psycho-motor activity. She was noisy, refused to stay in bed, struggled violently with the nurses and made numerous accusations against them, without cause. She was transferred in a fortnight to a mental hospital, where for the past five months she has continued in a state of excessive activity, boisterousness, talkativeness and destructiveness; the mood being one of peevishness, resentment and hostility, rather than elation.

On/

On what points is the prognosis to be assessed?

The home circumstances were unsatisfactory. The character was immature, probably of a hysterical type. There were prodromal symptoms suggestive of a hysterical condition. The onset of the psychosis itself was acute, with what might be considered to be adequate precipitating causes. Affect was preserved during the stupor and was characterised by fear on account of the disturbing nature of the hallucinations. The content of the psychosis was suggested by old wives' tales of the bad effect of amenorrhoea. The patient is now in a mental hospital, nearly a year after the onset of the psychosis.

The prognosis for the stupor reaction was good. The prognosis for the hypomanic phase was good. The present phase is more difficult to assess as regards prognosis, and to attempt a prognosis for the patient's future is even more difficult. This is the type of case where it is a relief not to require to use terms involving a sure prognosis. It can be said that a study of the type of psychotic reaction makes deterioration unlikely, but what of chronicity? Henderson states that these patients, who have exhibited swings of mood at the adolescent period, are of much graver prognostic risk, than those others of more stable temperament, where the initial attack has been in the third, fourth or fifth decades. Hysterical symptoms and/

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and emotional instability beginning at puberty, are unfavourable signs in this patient as regards her future stability. This is, however, different from suggesting that the illness will run a chronic psychotic course, for which belief there would be little justification. The fact of an initial hysteria may be of good rather than of bad prognosis, so far as the psychotic course is concerned. The psychosis was of acute onset and although refusal of food, mutism, hallucinations and negativism were present, there was little incongruity in the reaction.

If the outlook is good in respect of the possibility of deterioration and the probability of chronic psychosis, on what does the comparative stability of the result depend? It appears to depend on the nature of the environment discipline, the patient's reaction to treatment, the nature of her own internal environment, and her reaction to that. It is reasonable that her reaction to prolonged discipline of a rational nature will improve, rather than otherwise. With regard to her psychic reaction to changes in her own internal environment, the nature of these changes is important. She is already physically immature. In a report on a physical examination, it is said that she is immature for her years in secondary sexual characters. The question/

questions is, what will be her reaction to rational treatment on the one hand, and the physiological process of adolescence on the other hand? It is probable that reactions to these circumstances are likely to be towards improvement, rather than otherwise.

This is so far as arriving at a prognosis on a general examination of the data is concerned. Certain features of the psychosis in its relation to the life situation which are of special prognostic interest, are now selected for further discussion and illustrated by reports of other cases.

The points of greatest interest are the effect of the environment in relation to recovery; the importance of prodromal symptoms of hysteria; the nature of the affect during the stupor; and the sequence of the phases. The first phase was certainly hypochondriacal and was probably hysterical. It was followed by stupor, hypomania and by the present phase of lack of emotional control, with a resentful, aggressive affect, characterised by excessive psychomotor activity, in association with perseveration of hostile thoughts, rather than flight of ideas and elation.

These four points will be dealt with, seriatim.

Effect of the Environment.

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If there is any possibility of an improvement in the patient's environment, the chances of a better outcome may be enhanced thereby. This side of the question has not received a great deal of attention, although its importance is implicit in the conception of the reaction in terms of personality and life situation. Macfie Campbell⁽¹⁾ remarks that in War cases, the complete change in the life situation accomplished by removal to a hospital and an atmosphere of security, was important in the chances of recovery. He goes on to say that even in civil cases, although the importance of the precipitating situation is not so obvious and the personality as a rule less satisfactory, yet it should be kept in mind that, if a similar change were possible, it might lead to recovery. "Too often," however, "the life-situation is rigid and open to little modification, for many are chained to their family circle, their social environment, their economic task, their religious group." Strecker also recognises, with regard to his cases, that a highly important factor in recovery is the chance of satisfaction by reality;^(37, 44) while Sullivan emphasises that the social milieu to which a patient has to return has a great deal to do with his future. It is just possible that in some cases, permanent hospitalisation may depend, not so much/

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much on the inevitable malignancy of the psychotic illness, as on the reaction being associated with an inadequacy on the part of the patient to deal with the home situation, which may be unusually difficult. Conditions which favour the development of a psychosis, favour its continuance, and, while the more essentially malignant types flourish in any circumstances, there may be psychotic reactions, occurring in persons of weak character and unstable temperament, which may be effectively influenced by the conditions to which they return after leaving hospital; as also by the nature of these conditions to which they look forward in the event of their recovery, or improvement.

In the case of the patient, who has gone through a psychotic attack, where the adaptation falls short of that necessary for a return home, permanent hospitalisation may have an unfortunate effect and the adaptation demanded no doubt depends to some extent on the nature of the home environment. It is in such circumstances that the terms "benign" and "malignant" have only a very relative meaning. Sullivan believes that the outcome in some cases depends on the socio-psychiatric treatment. This is generally believed. If it applied to the majority of cases, the benign and the malignant could never be separated. Jawaharlal Nehru has a passage in his biography/

biography which deals with the effects of prolonged imprisonment, under certain conditions, on intelligent and active young men, and the resultant condition which he describes, strongly suggests a partial dementia. Deteriorating and non-deteriorating types may represent fundamentally different reaction types, as Kirby held in relation to catatonia. At the same time, when deterioration or chronicity are of very doubtful imminence, the very greatest importance should perhaps be accorded to the socio-psychiatric treatment, or the rational disposal. In all the cases reported in this paper, the ultimate prognosis is still to some extent doubtful, and in each case the nature of the disposal from hospital seems to be of the very greatest importance. This particularly affects the cases where the patient has been influenced by others in the embracing of unusual beliefs, or in the possession of excessive fear, which factors play an important part in the cases that will be later referred to. In such cases a relapse, or a failure to recover, may be attributed to a combination of the forces of bad heredity, unstable constitution and difficult adolescence - the importance of the life-situation, following a partial recovery, being to some extent neglected. This aspect will not be emphasised again, although it is important in every case. In the/

the case under present consideration, the patient is in the position of the spoiled child, living with her grandmother. She is in a position of privilege in her own home and is incapable of being controlled by either parents or grandmother. The chances of further improvement, should she leave hospital in an unstable condition, are therefore not very good.

RELATION TO HYSTERIA.

The second point of interest in this case, the relationship between hysteria and stupor, is not referred to in Hoch's book on Benign Stupors except in a footnote, with reference to mystic states. This relationship may not have received the attention that it deserves. Myer frequently refers to "hysteroid" types of reaction in schizophrenia. Sullivan⁽²⁷⁾ 33. refers to the dream-state in schizophrenia tending to become habitual or at least frequently recurrent, "and whenever this occurs the individual is definitely schizophrenic". He adds in a footnote: "That this conception of schizophrenia is broad enough to include the clinical entity, hysteria, has not escaped the writer. This is not the occasion on which to develop the implications of a classification of levels of consciousness, nor of the dynamics underlying major and minor dissociations."

The question under discussion at the present time, however, is not the theoretical relationship between schizophrenia and hysteria. The question is more specific: what is the prognostic significance of hysterical symptoms prodromal to a stupor reaction. Clouston is the only writer who has been referred to who stresses the frequent occurrence of stupor in persons/

persons of a hysterical type. He does not refer to its importance in prognosis. The nature of a type of psychotic or neurotic reaction depends more on the psycho-sexual maturity of the individual than on any other single factor. Hysteria is the typical reaction of girls at puberty. It would therefore not be surprising to find that psychotic reactions among girls, occurring at puberty, should be associated with hysterical manifestations. It is suggested that prominent hysterical elements at the onset of the stupor have a favourable prognostic import. This is discussed later in relation to mystic states. The reasoning is that the more suggestible the individual has been before the onset of the psychosis the more likely will he be to recover in favourable circumstances. Mention might be made of two further cases where hysterical-like symptoms were prominent at the beginning of psychotic reactions of the nature of stupor. These are mentioned in case it might be thought that the relation between hysteria and stupor was being pushed too far.

A girl of 18, of Italian origin, one of a family of six, was described by her father as having always been more difficult to look after than her brothers and sisters. She was stubborn, easily provoked to anger, became very tense and excited when crossed and had been more backward at school than the others. The illness/

illness for which she was admitted to hospital was said to begin only two or three months prior to this admission. The first prominent symptom was refusal of food, but she continued to eat sweets from her father's shop where she worked. She complained of pains in the chest and all over the body. She complained of being unable to sleep on account of fear. At times she would hold her hands against her chest and scream. She said that something was coming over her brain at times; she sometimes felt as if something was going to happen to her; and at such times she became excited and screamed. In the general hospital she was for the most part in a condition approaching opisthatonus and she was regarded as a typical hysteric by the physician and the psychiatrist. On admission to Jordanlane Nerve Hospital she gave the impression of being in perfect touch with her surroundings. At times she was mute ; at times she spoke in whispers. She threw away her breakfast tray and refused to eat. The conduct appeared to be dominated by a negativistic kind of hysterical reaction. Within two days however, she ceased throwing away her food, took what was given her, and in general became very easy to manage. She stopped speaking in whispers and became entirely mute. There was no negativism and no muscular rigidity. She gave the impression of being quite out of touch with her surroundings and in every way/

way presented the appearance of a psychatic stupor reaction. After three weeks she began to speak and in six weeks was walking about the grounds. The following is an account of her views on her illness and of her conversation when she first began to speak:

She remembers that she came from Crieff to Edinburgh but does not recollect being in the Royal Infirmary. Asked why she does not remember things she says she has every right not to and supposes it is stubbornness. She will not answer except to leading questions and then her answers are of doubtful relevance. Asked what caused the illness she said it was loss of blood, that it was due to a cut in the thumb, and added mysteriously that there were needles connected with it. Asked if it was these things that caused her illness she replied inconsequently - "Yes - in a way". Asked if she is happy she says - "Half and half", and if she was happy at the beginning of the illness she says - "All right in Aberfeldy - just an ordinary child, or thought I was". Q. "And in Crieff?".... A. "That was grief"..

Other apparently irrelevant remarks are "God knows what he did... Two powders... Well, I would run into the chemists for them.... No business to say he had cousins in America... I can put two and two together too.... I could curse myself for looking at Dickson Hawk's books and he was reading them too." She says that/

that she is not ill but just shaky and asked why replies that she can't get out of the clutches. Q. "What clutches?" A. "America".

She refers to quarrelling in the house, nudging each other, doing vulgar things. She was often taken off her guard and asked how she said - "Just looked around and stared at each other". She gives all the names of the people in her home but refers to it as "the strange place" into which she has been "put", as if she really belonged to somewhere different. The conversation is thus irrelevant and inconsequent. The patient sometimes looks out of the window and does not answer questions at all. There is no evidence, however, of hallucinosis but there is an absence of normal expression and grimacing.

On another occasion, asked what she is thinking about she says - "Kings and Queens and palaces and who shall sit on his throne and I want my rightful place."

Asked about menstruation she says she has lost her periods. Asked for how long she says - "More than five weeks - more than a year - 15....15 years."

While she was in a stupor the emotional expression was one of resignation and apparent apathy and there was no evidence of suffering. It has not been possible to gain an account of her emotions during the stupor from herself. If the condition was one of apathy it is/

is in contrast to the condition obtaining in the first case here reported and in the case next discussed.

She has now been in hospital for three months. She appears pleased with everything. Her manner tends to be grandiose. There is no excess of psychomotor activity, the condition in this respect resembling that of one awaking from sleep. Flights of ideas are present however with distractibility. The content of thought reveals exalted ideas. She believes that she is the daughter of the King of Denmark and has fantastic delusions around this theme. These she accepts placidly without insisting on them or reiterating them, as if there were no strong feeling behind them giving them an unsubstantial kind of quality.

If the commencement with a hysterical type of reaction in this case is indicative of a hysterical future for the individual it may also be indicative of a good rather than bad prognosis so far as the psychosis is concerned, implying, as it does, an attempt at compensation along with an attempt to keep in touch with the reality of her external social relations and a capacity to be influenced by them on a conscious level even if in a negative direction.

Another case is reported illustrating the same points, namely the occurrence of stupor with hysterical symptoms at the onset and the possible importance of these symptoms in the prognosis. This case, like the/

the two previous cases reported is also of interest in view of the evidence of emotional conflict and unhappiness during the stupor. A young woman of twenty-seven, who was a servant-maid in the hospital, had always been considered defective. She spoke little and had a very bad stammer. She did her prescribed work of cleaning and housework with care and attention but this was the greatest work she seemed capable of. She is a Roman Catholic. The illness began suddenly, after a visit to a grotto some thirty miles away. There were three prominent features of the illness. There were nocturnal hallucinosis, ideas of having sinned, and an attachment to one of the medical officers. The hallucinosis was of the Virgin, and of saints. The emotion was one of fear and unhappiness. Her stammer was not in evidence when she spoke. She seemed to be quite in touch with her surroundings and there was no evidence of hallucinations during the day. Her usual habit was to rush at one of the doctors, ask his forgiveness and ask if she had done wrong. She indulged in autoerotic practices, with muscular rigidity and voluntary muscular spasms without any interference with the genitalia. Although conscious of her surroundings and not stuporose she seemed unaware of the nature of the autoerotism and it would be interrupted by an access of fear and unhappiness when she would ask if she had done wrong and if she could be forgiven.

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It was thought likely that the nocturnal disturbances were similar in nature to such attacks of fear, with more severity and accompanied by the hallucination of a figure at the window. In this way her illness could be explained on a similar basis to the Freudian explanation of night terrors in children, which are held to be based on guilt feelings in association with masturbation. After a week's illness, this patient who, it must be remembered had always been considered of defective intelligence, became mute, more out of touch with her surroundings, constantly restless at night, and entirely under the influence of the thoughts in her own dream state. The muscles were rigid. The expression was one of misery and she constantly made tentative attempts to approach her doctor apparently with a view to having similar reassurances as she had when able to formulate her questions but was no longer able to express her thoughts. She continues at present, after a month's illness, in this condition. The condition is regarded as one of stupor of acute onset, beginning with hysterical symptoms, and occurring in a defective who had a very bad stammer. Most of the indications are in favour of a good prognosis although the defective condition is a grave complication. The interest of the hysterical nature of the onset can be repeated again with reference to this case. Such a case/

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case can be distinguished from one beginning with a sudden hallucinosis without apparent relationship between the patients conduct, the social relationships and the morbid symptomatology. It is true that in this case the hysterical reaction was not so well appreciated by the patient as in the former case and in this respect it approximated more to a schizophrenic type of reaction.

Guilt feelings and experiences of terror occur in association with autoerotic practices and a poorly awakened appreciation of the nature of sexual experiences. Analysts have regarded night terrors in children to be of this origin and we have given an example in a defective who developed a stupor reaction, beginning with what were apparently hysterical symptoms, of a similar nature to night terrors. In the following case, where the illness began at puberty, the psychotic symptomatology would suggest some such process. The psychosis is of a more frankly schizophrenic nature. Although the patient said that the illness began with a hysterical upset there is no evidence of functional symptoms prior to the onset of the frank psychosis. The patient made a good recovery and was in excellent health when she left hospital. Seen six months later however, although able to carry on her work satisfactorily and to lead what was described as a happy life at home she seemed to have an attitude of suspicion/

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suspicion and reserve in contrast to her frank and open manner on leaving hospital.

This case is in contrast to the foregoing there being no prodromal hysterical symptoms.. It is probable however that the illness was of a similar aetiology. The reaction although acute in onset was marked by complete absence of appreciation of reality or of seeking assurances on account of her fears. There was no question of symptoms being suggested to her or of her attempts to square her experiences with her social relationships as occurred in the prodromal hysterical symptoms. The symptomatology was in consequence more bizarre, more individualistic, and more ominous.

The patient is one of a family of eight whose ages range from 20 to 4, all being reported as healthy. One child died at the age of 1 year 10 months. The patient is the third in the family and is fifteen years of age.

As a young child she had measles and whooping cough but has always been regarded as being physically healthy. She has even shown some athletic distinction having certificates for swimming.

According to the mother she did quite well at school, and there has never been any suggestion that she was not as bright as her brothers and sisters. Her general conduct has been marked by activity and brightness/

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brightness of disposition with a prevailing mood of happiness, and it is quite impossible to get any indication of psychopathic traits from the mother's account.

On leaving school in March of this year patient attended the Juvenile Instruction Centre and had a job as message girl in a Fruiterer's shop for two months. Three months ago she was sent to work in Glass Works. According to the mother, she disliked this work but did not complain very much about it and it was understood that some effort would be made to get her out of the place in the New Year. According to the mother she was associated with a rather coarse type of girl in these works and the mother appears to feel very guilty, attributing the illness, at least in part, to the unsuitable work.

So far as the patient herself can give an idea of her early life, her story corroborates the mother's account of her previous normality.

It is understood that a few weeks before the present illness the patient complained to the Manager of a certain forewoman in the Works and was told that she was not to pay any attention to her and that she had to be thick-skinned for this kind of work. Three days before admission the patient came back from work in the forenoon and complained of the girls telling her to get on with her work and said that there was a book and/

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and some glasses gone amissing and that she was being blamed for taking them. The mother interviewed the foreman who expressed confidence in the patient. The patient was pacified, but the following day returned from work at the same time in a similar excited state. On the day after that the mother kept her at home and sent for the doctor thinking that she was rather nervous and all that day she had crying turns saying - "Its my nerves - I know its my nerves". She had not slept the previous night but continued taking her food satisfactorily. She was admitted to hospital on the third day of her illness.

Patient cannot give a clear account of her history, especially for the last few months. She gave varying ideas of the time of onset of the illness which she describes as the time when "these people" began to take an interest in her - apparently meaning the people at her work associated in her mind with the hallucinations.

She was supposed to be bad; neighbours had a spite against her mother; everybody had a spite against her. They came into her bedroom, sat on her bed and blethered away. Used the electricity and wireless. She could not get out of bed for the rats which they brought in. When she came here she knew too much for her age and was supposed to be bad. They were supposed to be writing books about her and she was supposed to be/

be bad. "They were all going to say something about my dirty habits - she was going to see if I could eat the same as the rats." She refers to neighbours being against her. The mother corroborates this. A man who lives above them makes a habit of shouting abuse at the patient on the stair or from the window. A woman neighbour was sent to Bangor 7 or 8 weeks ago causing a good deal of excitement in the neighbourhood and the patient was a good deal upset at the time.

On admission she was in a state of terror and made a great scene of shrieking in the hospital when taken to bed. Such episodes have occurred since but not frequently.

Her conduct showed a steady improvement. During the first ten days she had frequent injections of morphia which have not been necessary during the past fortnight. They had been administered on account of great restlessness associated with shouting, shrieking, constant getting out of bed and refusal of food. Morphia was sometimes given so that she could be satisfactorily fed on fluids. There has been frequent incontinence.

On admission she was almost entirely inaccessible but this gradually improved. Sometimes her answers did bear a direct relation to the questions asked. Sometimes the relation appeared one of chance association of words and at other times it is not possible to make out/

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out a relation at all except that she spoke as if she were answering questions. She varied from reticence to garrulousness and the impression was that during periods of reticence she was occupied by hallucinosis - visual and auditory.

The expression was sometimes entirely blank; at other times she expressed contempt, disgust (spitting), suspicion (looking sideways apparently under the influence of hallucinosis), and surprise. Perhaps the most frequent expression is one of sullenness, while the most striking is one of fear. There is no appearance of elation. There is frequent grimacing. The only feeling that the patient admits to is one of fear. "I'll be dead in a wee while. I know you killed us first with the knife - that's yesterday - my own head - that's right. You need not tell us that it was the Professor that killed us first". Attention was almost impossible to get and was replied to in such a way as this:-

Q. How old are you?

A. I'll tell you when I am dead.

She spoke of "earth" and "water" and of "going to the rats".

When she came to hospital the content was taken up with the idea of death. The content is marked by delusions of persecution resulting from hallucinosis and the content appears entirely to depend on this factor/

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factor, answers to questions being of delusional material. For example:-

Q. Are you happy or sad?

A. When I see this woman - I don't feel like talking or anything when she is after me.

Other examples of conversation:-

"She is supposed to have been in contact with half of my head. I don't understand it at all for it is the first time in my life I have been trained to come like that".

The patient felt as if something were going to happen "the same thing that has been happening for nights a few minutes after I lie down. Seemed to come to the bed every time. Taken by surprise. Watched me on the bed. Had a knife. Puts it up my face. Put her tongue into my face and seemed to draw the blood out of my face. Drew the blood out of my head. I am supposed to be half a man and half a woman. At night she put things through my ears. She put poison into my stomach. She put rats into my body. She has got an awful spite against me, tried to frighten me. I haven't exactly seen her but I know the way she talks and everything. Seemed to be a man sometimes and a woman sometimes. It seemed to be the blood that she breathed through her nose and throat. I don't think she is a woman - I think she is a man, if you ask me anything. They all call her "The Lady in Red". She seems to come into my mind just now. She has got two or three voices. They breath the blood through the nose and throat".

Such is the report of the terror inspiring hallucination at the height of the illness. The illness was of accute onset. The hallucinations and evidence of tears were apparent during the first six weeks in hospital and she was well when discharged in three weeks but, as has been said, the condition on a re-examination showed a certain relapse.

The fact that the illness did not begin with an attempt at a hysterical adjustment is considered to be of less favourable prognosis. The accute onset was of good prognosis and the outcome of the attack was good. In place of an assessment of the adequacy of the previous personality it must be conceded that in these cases occuring at puberty the fact of a severe psychotic disturbance at an immature age must be regarded as militating against an adequate adult social adjustment.

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AFFECT IN STUPOR.

The third question raised in the consideration of the first case reported is the question of the preservation of affect in the stupor reaction. Hoch¹⁰ believed that the affect was one of apathy. Clouston held that in stupor reaction the affect is one of fear of a stupid and dulled nature. Henderson⁽¹¹⁾ believes the affect is usually retained and is often one of acute misery.

In the cases here reported, all views are seen to be true. One case shows every evidence of misery; in one case the anamnesia revealed that there had been a state of 'stupid fear', and in a third there was no evidence of there having been any emotion at all.

It may be that those with least evidence of emotion are those where the regression is more complete and acute, and in these cases the prognosis may be better. The presence of evidence of emotion may to some extent be related to the degree of negativism, muscular rigidity being possibly an index of both. It appears paradoxical to state that where depression is least evident and apparent resignation most evident, the prognosis is better. It is, however, in line with Sullivan's views on the better

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prognosis in what he regards as the most characteristically schizophrenic process in dementia praecox, namely the Katatonic. It is supported by Hayes Newington:-⁽⁶⁾

Anergic

(Acute Dementia Type)

Emotional Capacity: Nil, or almost so. Eyes are often suffused with tears, but this seems to be due to derangement of the lachrymol apparatus and is, I think, additional evidence of anergia. Features relaxed, eye vacant and is not constantly fixed.

Delusional

(Melancholic Type)

Emotional Capacity: There is evidence of grief, fear, etc., in the facile (Hoch quotes 'facial') expression - wringing or clasping of the hands. It is very rare to find tears shed. Great contraction of the features. Eyes fixed on one point, usually upwards or downwards, or else obstinately closed.

It will be remembered that Clouston's prognosis in the first type was 'a very curable form' and in the second a fifty per cent recovery rate.

Hoch foundered on this paradox. The less evidence of emotion, the better the outlook. Apathy

could therefore be a term like depression and elation characterising a recoverable condition. But calling this 'depressive stupor' he included cases with more emotional expression and worse prognosis which Hayes Newington had more wisely put in the same group as the ones we would at present designate as Katatonic. If Clouston's better prognosis in the anergic group is right, there is no doubt a great principle of prognosis involved, perhaps to do with the 'purity', the 'lack of incongruity' or the 'lack of distortion' in the emotional response, a complete resignation indicating a better prognosis just as a pure elation is better than one mixed with perseverative persecutory trends. Following indications of the study of the psychoses of those of Spearman's school, it may be that it is better to see increased fluency in the mania without increase in perseveration and in the depressive increased perseveration without increased fluency. So in the stupor, although affect is commonly retained, it may be of better prognosis to have a complete absence of emotional expression and a minimum of emotional appreciation.

It is significant that in the cases here described the patients with most evidence of preceding

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hysteria have shewn most evidence of emotion in the stupor as if the dissociation were more complete and the emotions less conflicting. The greatest evidence of emotion was apparent in the last case reported where the frankly schizophrenic features were most prominent, where there was a more pronounced hallucinosis and a mal

The conclusion is suggested that although Hoch's classification is not useful, and although his denial of affect in stupor is not supported by common experience yet good prognosis in stupor may be associated with apparent apathy more readily than with apparent emotional disturbance.

We have suggested that in cases of stupor where a hysterical element is present apparent absence of emotion may be of better prognostic significance than obvious preservation of affect. This is a limited though important group of cases. It is to be noted that apparent absence of affect involves the assumption of a spirit of resignation which is indicative of a harmony of affective forces.

With regard to schizophrenia in general it is the harmony of the affect in relation to the thinking and conduct rather than its preservation that is important although preservation in itself is generally regarded as a good sign. Meyer gives pride of place to incongruity or harmony of affect among prognostic signs.

White considered that malignancy depended on two factors which in their final analysis may perhaps be the same. These were the depth of the regression and the inclusion in the regression process of archaic material. He laid greater stress on the inclusion of the archaic material and as examples of such inclusion suggested the following - delusions that certain bodily excretions, urine, faeces, sweat, tears, contain elements of the personality, delusions of food, air and sound as impregnating material, cannibalistic symbols, water as a birth symbol; such symbols as fire as a libido symbol ; mythological animals ; certain delusions regarding the heavenly bodies particularly the sun. He regarded depth of regression as being responsible for 'the lack of insight of the patient, for his failure to recognise his symptoms as emanating from himself, his failure to recognise his own wishes, to appreciate the personal source of his symptoms.' Sullivan regards these features as being due to disparity in the depth of the regression of which he says, 'It may well be that this factor bears some important relationship to the unwillingness or inability of the sufferer to accept the personal source of much of his psychotic phenomenology.' The depth of the regression of itself he does not consider of so much significance, regarding the hebephrenic 'whose behaviour seems to

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rest at the 'depth' of early childhood or late infancy' of much more grave prognosis than the catatonic, 'who had approximated an intrauterine regression.'

Henderson and Gillespie similarly point out that 'many patients apart altogether from those who show what we term schizophrenic reactions - regress to a very primitive level and often exhibit mental material of an "archaic" nature yet recovery takes place. We have seen many cases of a schizophrenic kind who have seemed to regress to a very early infantile level and who exhibited many symptoms which could be interpreted as archaic and yet have frequently improved to a very large extent. Sullivan holds that the distinctive mark of the schizophrenic process lies in a dissociation of mental structure in such a way that the disintegrated portions regress in function to earlier levels of mental ontology without parallelism in individual depth of regression. Further he regards the dynamics of these several regressions as of final importance in determining recovery, chronicity, or a dementing course. For a study of these factors he emphasises that schizophrenia has to be recognised as a mental process regardless of anything other than the individual's behaviour and thinking during the disorder. He proceeds to a study of the actual content and details of behaviour with a view to classifying

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the phenomena that are of value in determining the unfavourable factors. This study would appear to be the most adequate recent account of the factors observed in the psychosis which are of the greatest value from the point of view of assessing the prognosis. It is a study of a group of brief schizophrenic illnesses which recovered with definite favourable change in the personality. The histories included such features as psychopathic traits in childhood, ungovernable temper tantrums, destructiveness, emotional instability of high degree, excessive sensitiveness, extreme selfconsciousness and severe neuroses. He appears to indicate that outcome may depend on to what extent the psychical reorganisations following on the several regressions can be regarded as conforming to adaptations to reality. He speaks in terms of the paranoid, hebephrenic and catatonic groups. With regard to the more paranoid reactions he regards illogical or bizarre persecutory beliefs as showing transient reorganisations while beliefs that are rather consistent logically once a small group of false premises have been accepted are to be viewed as unsuccessful outcomes and of unfavourable omen. The hebephrenic reaction may show a loss of egoistic striving which, with the development of mannerisms concomitant with frank excretory interests is of poor prognosis, but again the antisocial desires and more

adult egoistic satisfaction may still be in conflict and among such cases the outlook may be better the deterioration being due to 'a splitting of the sentiment of self-regard - a variety of the partial goal of mental life instead of the integrating ego dominating or striving to dominate the innate and derivative tendencies.

The better outlook in the catatonic cases he associates with the fact that they neither have recourse to comprehensive projection nor show such a form of multiple splitting as is shown in the second hebephrenic group. Contrasted with the true hebephrenic condition where there no satisfactory adjustment but rather loss of egoistic strivings and perverse (antibiological) pleasure taking, the catatonic is in a condition of unabated conflict. The purely schizophrenic dissociation is greater and the regressive processes deeper, the functions appearing in the content and behaviour lower and lower in the scale of ontogenesis.

From a consideration of these views it is clear that the prognosis does not depend on any single character of the regressive process, such as depth, inclusion of archaic material or the disparity of regression with resultant differences in levels of motivation. Rather it would appear that the process of psychical reorganisation is of greater importance considering both the extent to which a conflict

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between adult and earlier desires is retained and also the nature of the re-organisation adjustment, whether it is compatible with final adjustment to reality. This conception, emphasised by Sullivan, has been considered in various terms and less clearly by other writers. White, for example, writes as follows: 'We must in the first place make some effort to evaluate the nature of the conflict, that the patient is suffering from and then by watching the patient see how the constructive and the destructive forces are working as we see them brought up in the symptoms of the psychosis. If we bear in mind the fact that these two sets of forces are always at work we can see efforts at restitution taking place here, failures of such efforts taking place, and, by a longitudinal section of the symptomatology extending over a reasonable length of time we get some sort of idea as to which set of forces may be succeeding.'

It will be seen that evidence of the presence of conflict may of itself be regarded as a good sign even although the nature of the re-organisation that it may lead to is not known. The most common way of judging the amount of conflict present is to speak of it in terms of affect and to estimate the amount of feeling that the patient is experiencing.

With the exception of the single case of

stupor with apparent apathy, all the cases here reported showed a well preserved affect and evidence of considerable emotional conflict. In what further way can the theoretical considerations of the dynamics of the regressive process be applied to these cases? The cases have been considered in relation to the features in the psychosis and in relation to the onset of the psychosis. It has been mentioned that in the first case the course of the illness was of particular interest and a brief report of a further case with Macfie Campbell also considers affect in relation to the other symptoms and the total reaction particularly associating affect and phantasy as antagonistic elements, the more the affective symptoms fade into the background, the more the phantasies dominate the picture the more ominous the prognosis, but he prevents hasty deduction by adding: 'but this ominous development can go much further than is usually supposed with complete restoration to previous efficiency still a possibility.' The same features have been more crudely described by Kasanin who also emphasises the co-existence of affect and phantasy and the importance of the balance held between them in the prognosis. The emphasis is the same in Henderson and Gillespie's phrase: 'so long as the mood and the thought and the conduct are kept

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well in harmony.

Although the emphasis is thus put on the harmony of the affect and the other features, all writers assume that presence or absence of affect is in itself of the utmost importance. Only when it can be evaluated can its incongruity with the other features be considered. Since the difficulty of estimating affect is regarded as a commonplace statement discussion can very profitably be directed to the question of its more accurate estimation. Strecker emphasises the importance of this question: 'Again our methods of testing emotional resiliency and depth are markedly restricted. Slight disturbance of consciousness, racial or even individual habitual inadequacy, or the peculiarity of the expression of feeling may prevent moving affective trends from reaching the surface in a form which is rightly interpreted by the observer.' And again: 'The very incompleteness of our information should lead us to employ caution in pronouncing deterioration of affect simply because there is some species of catatonia exhibited, particularly when there is the history of unmistakeable antecedent emotional stress.' He quotes Wundt: 'The principle that observation is wholly inadequate when applied to psychical processes which present themselves in the natural course of life holds especially for the emotions.'

Sullivan directs himself to the same problem.

He quotes Tuke as saying that there were cases where the ablest alienist would be unable to decide whether the mind was what the outward expression would lead us to infer - a complete blank - or the seat of such intense depression as only to simulate dementia.

Sullivan then gives it as his own conclusion that the alleged indifference, apathy and emotional disharmony of the schizophrenic is more a matter of impression than a correct evaluation of the inner experience of such a patient. His method is to employ the psychogalvanometer, to note the refinements of facial expression and in various ways objectively to determine somatic tension. The hyperglycaemis index is a further method used to estimate the extent of affective tension present in the psychotic patient.

The application of the Spearman psychology may also have important bearings on the estimation of emotion, on account of its making possible objective analysis in a field previously open only to subjective appreciation.

The problem of degree of affect and its effect on prognosis resolves itself into a discussion of the ways in which affect can best be estimated. Direct appreciation of the affect being entirely dependant on personal impressions without reference to

scientific standards it would appear that indirect measurement may lead to more accurate estimation whether by examination of emotion in its somatic expression or in its effect on the cognitive and conative fields of mental life.

Affect, however, when it can be evaluated in the course of a schizophrenic psychosis is regarded as favourably affecting the psychosis. When there are signs of emotional tension at the beginning of the psychosis the interpretation is not so easy. Strecker holds that an illness arising from a situation involving emotional stress is of more favourable prognosis. There does not appear, however, to be any control study - any study of the incidence of emotional stress at the beginning of psychoses that proved malignant. Extreme cases, where the schizophrenic illnesses were preceded by psychoses where the emotional tone was so prominent that they were regarded as manic-depressive have, however, been occasionally reported. Macfie Campbell, for example, reports the case of a well integrated personality experiencing a depression with recovery, followed by manic features and schizophrenia. Henderson and Gillespie report a case showing a clinical picture resembling a manic excitement with discharge after a satisfactory adjustment had been made and admission to hospital fifteen months later when a progressive

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schizophrenic psychosis supervened. Stress is laid on 7 psychosis which might have been thought to forbode malignancy. Mapother gives it as his opinion that 'cases presenting the manic-depressive syndrome in absolutely pure form during their early stage, do sometimes end up as typical dementia praecox.'

An attempt has been made by Sullivan to distinguish between the kind of depression which occurs at the beginning of a schizophrenic illness and the depression of the manic depressive psychosis. Instead of retardation with pre-occupation with a few grief-provoking situations associated with personal sins and errors representing 'a standstill of adjustment', they feel that all is wrong for some more or less inscrutable reason. The content is not simple but burdened with pressing distresses and becomes more and more wrapped up in fantastic explanation and efforts at remedy. The prominence of perplexity is emphasised and the whole is regarded as representing a striving to get away from painful stimuli, and is contrasted with the typical absence of struggle associated with the true depression. He does not associate such a condition in any way with prognosis, nor suggest that such an emotional struggle reflected in the appearance of a type of depression is of good prognostic value, but introduces the

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subject by referring to the depression as a characteristic feature of the prodromal period.

It would appear to be the general opinion that while schizophrenics commonly show evidence of considerable emotional turmoil at the outset of the psychosis, the continuance of such tension is of good significance. On the other hand it is emphasised that in the catatonic state which is of better prognosis than the other types of schizophrenia, states of stupor with no evidence of continuance of affect, occur. It has been pointed out that affect being frequently difficult of valuation it may be present without much evidence. Although this indicates that it is difficult to assume the absence of affect it also indicates that it should never be presumed retained without positive evidence, and significance is best confined to the affect which can be objectively appreciated. To suggest that a patient may have retained affect because a similar patient recovered is to take the consideration of the meaning of affect out of the field of clinical psychiatry.

The universal conclusion is that preservation of affect in harmony with the behaviour and thinking is the best prognostic sign. Where, however, a hysteroid reaction leads to a further regression, without disparity in the depth of the regression and

without discordant or incongruous features, in such a condition the apparent absence of affect may not be of bad significance. This implies that regression of itself is not of bad significance, which indeed has long been conceded. The need at present is to extend to the term schizophrenic the freedom from prognostic interest that has long been accorded to the term regression and to much the same extent to the term catatonic.

It is not the extent of the regression but the dynamics of the regressive process that appears to be of importance. Meyer's distortion or par is translated by Sullivan into disparity in depth of regression which is regarded as the true schizophrenic feature.

Even these features are not so important according to the authorities as the capacity for psychical reorganisation

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appreciation of the affect being entirely dependant on personal impressions without reference to scientific standards, it would appear that indirect measurement may lead to more accurate estimation whether by examination of emotion in its somatic expression or in its effect on the cognitive and conative fields of mental life.

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*Introductory page on the fourth point
- the succession of phases in relation
to prognosis - is missing.*

a similar succession of phases will be given. In both cases there were hypochondriacal, stuporous and hypomanic phases in succession and in each case the hypomanic phase was followed by a phase characterised by resentful antagonism and antisocial conduct. In these cases the psychical reorganisation of the repressive processes may be said to have been inadequate although not to the extent of leading to dementia. Using descriptive terms the patients may be said to be in danger of settling down into a chronic state of antisocial antagonism which has superseded a phase of elation in each case. From the point of view of prognosis such a phase may be described along with other groups of antisocial conduct taken than with the psychoses proper. The symptom is the possibility of chronicity without deterioration.

The second of the cases referred to is now briefly reported. This report concludes the section dealing with stuporous reactions and the features evident in the psychosis itself in relation to prognosis.

The patient, a native of Orkney, began work on the land at the age of eleven when he went to herd cattle on a nearby island. He continued working on farms till the age of 20 when he went back home on account of a pain in the chest. His inability to work came/

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came as a great surprise to his people for he looked well and when the doctor said there was nothing wrong with him they were all the more surprised for he was not the kind of boy that would shirk work of any kind. He was naturally of a quiet nature but at first when he came home he was just as cheerful as he had been before his illness, and visited his friends round about on his bicycle. However as time went on he cycled less and seemed to care less for going out visiting his friends or for paying an occasional visit to the cinema which he had previously enjoyed. He remained quite active in the house. After three years of being unable to work he became very will and for 21 days ate no food. He then started eating again but for a long time vomited a good deal after every meal. Even still he kept in wonderfully good spirits taking an interest in things of local note and reading books and newspapers. During the following winter he seemed to loose interest in things and never went out. He did not seem to sleep much at nights and latterly lay all night in a sitting up position bolstered up with pillows. His mother considers that he was greatly influenced in health by whether or not he was able to get insurance benefit on account of illness and that he became noticeably worse when his health insurance was stopped. He was certified in the following summer four years after he first went off/

off work. He told his doctor that he was afraid that he had been infected with venereal disease, from a woman he had never spoken to but only heard at a distance. The doctor also relates that he had not washed for three years. He had become dirty in his habits and unmanageable. He would not go outside the house nor change his underclothing. He sat quite still with a vacant expression while he was being discussed answering questions very slowly and foolishly. At times he would be noisy and laugh and talk so that he could not be stopped. Sometimes he kept on repeating a word or phrase many times. One of the phrases he repeated was 'dirty whores.' When he came to hospital to hospital he was usually to be found standing behind a door in the ward, not speaking to anyone but gazing into space and murmuring one or two words that could not be understood. His answers to questions were coherent but short and slow. Questions had to be repeated and he would pause long before a reply. He did not give the impression of being at all suspicious. He attributed his illness to pain in the back and also to trouble at home on account of the lack of consideration that his brother showed to himself and his mother. He believed that he had an infection from a woman on account of the fact that her father called patient's mother a bad woman. He said he was unable to work on account/

account of chest trouble and some sort of infection. Again he attributes his trouble to his lifting a heavy stone some years ago in the course of his work.

For nine months after admission the patient remained apparently apathetic although able to do a certain amount of outdoor work. Then suddenly he went into a state of mutism taking up very strange attitudes which he maintained for some time. As a rule he lay curled up in bed in a condition of extreme flexion but if permitted to get out of bed he knelt on the floor also in an attitude of extreme flexion or more commonly he would lie curled up under the bed. He took his food fairly well. After a week or two of this condition he could be got up and dressed. He then went round the garden patch picking leaves from the trees and trying to eat them, apparently enjoying himself. He improved greatly put on a great deal of weight and the stuporous reaction became gradually replaced by a hyponanic phase.

He became euphoric and made constant efforts to get away. He was constantly smiling, but the mild degree of hypo-mania is not present with flight of ideas or gross distractibility. He relates that while in the stupor he was passing through a "degree of law presided over by the Master of the Asylum" who appeared to him as a voice. He was accused with other people of stealing and/

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and robbing, but after a month they came to a settlement. He was accused also of black mail, because people had heard him say that he had contracted venereal disease from a girl he knew at home.

The attempts to escape from hospital were associated with a disregard for the authority of the staff of nurses of a playful nature. Now, however, after three years in hospital he is more difficult in his behaviour than at any previous time. He appears to be in good touch with his surroundings. He is antagonistic to the other patients as well as to the staff. He appears to have an extreme lack of emotional control his delinquencies being apparently on a fairly consciously appreciated basis. It will be interesting to see whether such behaviour, usually lifelong, if present, can be recovered from if it occurs as a phase in the nature of a hypomanic reaction.

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Presentation of Cases.

Second Group.

In this second group of cases there are four full reports of cases of patients whose psychoses began in, or very near to, the third decade. Short reports are also given of a number of cases of patients of a similar age group which cases illustrate some of the points that are brought up with regard to the relation of the psychotic content to prepsychotic influences. These short reports refer to patients who are natives of the Orkney Islands and in relation to whom the prognosis requires to be considered in rather a special way in view of the constant finding of symptoms in the psychoses of a schizophrenic nature owing to the nature of the environment and upbringing. Of the four cases that are fully reported two are considered of better prognosis than the others. There is a further brief report of a case which is inserted in contrast to the other four. The psychosis in this case ran a clearly malignant course.

These patients are to some extent in contrast to the cases in the first group. The average age is about ten years in advance of the average age in the first group. The patients broken at the stage of final adult adjustment rather than at the onset of puberty. In all cases the psychoses were of acute onset. In all cases affect was well preserved. Yet the prognosis is not quite clear and attention is concentrated on the prepsychotic personality and character and the nature of/

of the patients' reaction to the social environment. In two cases the characters were unstable but the social adjustments were quite good. Both patients were of a suggestible type and the environmental influences had conduced to abnormal modes of thought which developed into delusion. In the other two cases these influences were present to some extent but the psychoses were more individual and less social in the early stages. The impression is that the first two patients had been ~~potentially~~ psychotic from adolescence and had been assisted into their psychoses by environmental influences. The other two patients however had psychêres as natural and inevitable consequences of the nature of their propèssively social development. The conclusion is stated here baldly but is discussed more fully after a report of the cases.

The first two cases are reported together and there reports are given before the discussion on prognosis. In these cases the onset of the psychêres occurred at the age of 28 and 31 respectively. Manic and schizophrenia or paranoid features are prominent in both cases. It should be mentioned that the cases bear a resemblance to three cases of exalted delusional states in the series of cases of recovered cases of schizophrenia reported by Streeles and Wilby (Cases 6,9, and 18 in their series). The ages of these patients were 29, 31 and 33. One of the/

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the cases that Kasanin reports under the heading of the Acute Schizo-Affective Psychoses shows a similar type of mystic exaltation on a delusional basis. It is case No. 3 in his series and the patient's age was 33. A third reference to a report of a similar case is that of a case reported by Henderson in his monograph on Affective Reaction Types with the heading: "An unusually interesting case showing the close conjunction of manic depressive to paranoid states." The two cases that are reported first and one of the others that is reported later have a strong religious and mystical bias. They are similar to the cases that Dercum described in his book, "A Clinical Manual of Mental Diseases." Since his description is a very near clinical description to our cases the description is here quoted at length. He uses the term mystic paranoid to describe such cases. On the basis of previous discussion on the subject in this thesis it has seemed more reasonable to include the cases in the schizophrenic grouping. The first two cases, could, on symptomatic evidence be referred to as cases of mania with grandiose delusions. Dercum's description is as follows:-

"Much more interesting than either the hypochondriacal or self-accusatory forms of paranoia is the form to which the term mystic paranoia has been applied. Here the patient again passes through a hypochondriacal period, characterised by vague and bizarre sensations. The patient may as before attribute them in due course to persecutory agencies, but sooner or later they receive a mystic interpretation; that is, the patient believes himself either to be the victim of evil spirits, demoniac or diabolical agencies, or, perhaps, that his sufferings have been inflicted upon him in accordance with the divine will. It is noted that patients who develop mystic paranoia frequently present in their childhood abnormal religious tendencies; thus, they will dwell upon and discuss religious questions to a morbid degree, devote themselves with abnormal fervor to their religious duties, make premature or precocious religious profession or manifest phases of religious exaltation. It can readily be understood, also, that if a child presenting such peculiarities be in addition made the subject of undue religious training, or be brought up in an atmosphere too austere and repressed, an atmosphere in which the depressing features of religious doctrines are over-emphasised, the abnormal tendencies of the child may become greatly exaggerated. However, we must bear in mind that paranoiacs are born, not made, and that the delusional lunacy from which they suffer does not require an improper religious training to develop it; the latter merely, in suitable instances, enhances and hastens the development of the symptoms. In many cases the delusional state observed in the period of full development may properly be looked upon as merely an outgrowth or amplification of the abnormal traits inherent in the child.

As has just been stated, the visceral and general somatic hallucinations of the depressive period are ascribed by the patient not to the persons about him, but to mysterious and occult causes. He is being persecuted by evil spirits,
by/

"by sorcerers, by the devil, or he may believe that he is being punished by God. One of the remarkable facts of mystic paranoia is the great frequency and prominence of sexual phenomena. These doubtless have their birth in genital hallucinations; of all the visceral hallucinations these lead to the most striking results. The patient is erotic; sexual excitement is marked; he gives way to masturbation, practises sexual congress, sexual excess, perhaps sexual perversion. Every sexual act is preceded by painful struggles and followed by remorse and discouragement. Sometimes the patient's eroticism is purely mystic; he or she is in love with this or that saint, this or that divine personage. Women are subjected to carnal temptation by the Godhead to test their virtue, or they claim intercourse with the Deity, are pregnant, and will give birth to the Saviour. The sexual hallucinations seem in some cases to be very vivid and to be accompanied by very active sensations.

Sooner or later visual hallucinations are added. Indeed, it is characteristic of mystic paranoia that visual hallucinations, like the sexual hallucinations, are very frequent and prominent. The patient who is absorbed in his excessive piety becomes more and more intense in his devotion, spends his time almost continuously in religious contemplation and prayer, and finally begins to hold communication with God, the Saviour, the Virgin, the angels, who appear to him in visions. The hallucinations may consist of bright lights, brilliant halos, glorious and imposing figures, who smile upon him, make signs and gestures. Usually the patient tells us of the things he sees; later, in many cases, it is evident that the visions also speak to him. In other words, in the progressive development of symptoms hallucinations of hearing are added, and the voices tell him of the great mission, the great future that is his; he is destined to save the world, to reform mankind, he is to be the Messiah, is to represent God on earth. The expansion grows until he not infrequently asserts that he is "the Christ" or God himself come back to earth. During the seeing of the apparition and the hearing of the voices, the patient may pass into a clearly marked hysterical crisis. He may pass into a condition of ecstasy, and not infrequently he assumes fixed or cataleptic attitudes.

In mystic paranoia, as in the other forms, the patient passes through a period of depression, a transformation, and a period of expansion. The patient/

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"patient looks upon his period of depression, with its trials and sufferings, as a period of probation, during which he is tested, chastened, prepared for the great rôle to follow. The period of depression is commonly quite prolonged, the ideas are evolved gradually and slowly systematised. Sometimes the transition to the expansive stage is very gradual, so that both persecutory and expansive ideas may be present at the same time. Thus, while the patient believes himself to be ordained, and is actually engaged in carrying out the divine will, he is, notwithstanding, suffering from the evil influences about him, is subjected to carnal and other temptations by the devil.

Quite commonly the mental state of the mystic paranoiac is such that his pathologic condition is readily recognised. Sometimes, however, he is a man or woman of powerful personality, of force, of natural eloquence, and of convincing manner. Under such circumstances, he not infrequently secures a following, and one, too, that may grow to huge proportions. One need hardly mention the divine healers who arise in every age and in every country, nor speak of those who actually found new faiths and creeds. Mystic paranoia is a danger that is real, grave, insidious. The unknown, the mysterious, the occult inspire awe and dread; they also weave a hypnotic spell; they bind in hopeless impotence, chain in blind fascination the simplest workings of the mind. The every-day facts of life, of existence, are denied and absurd delusions substituted. Realities are hallucinated away and replaced by the intangible figments of mental disease. The communicated madness so arising may become epidemic and may last for centuries. The role played by the mystic paranoiac is well illustrated by the history of Sabbatai Sebi, so dramatically told by Zangwill in his "Dreamers of the Ghetto". Sabbatai, a typical mystic, after a long preliminary period of depression and preparation, passed through a typical transformation, and finally announced himself as the Messiah. He performed miracles, was accepted by many thousands of Jews, and even by Gentiles, both in Palestine and Europe, and even after the collapse of his pretensions and his death, a sect, the "Dormeh" of Salonica, long survived him.

Mystic paranoiacs are not physically as dangerous as the ordinary persecutory cases, and yet their delusions sometimes lead them to the performance of barbarous and cruel acts. Now and then a mystic will, in obedience to his hallucinations, slay his own child - perhaps as a sacrificial offering or in order to hasten its advent into paradise. Others during/

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"during the period of depression and suffering, a period often regarded by them as one of penance, will scourge themselves or subject their bodies to self-inflicted torture. The patient believes that these punishments chasten him and are pleasing to God; he often regards them as his only means of salvation. Sometimes he mutilates his own body; thus, the Skoptzi, a mystic sect of Russia, castrate themselves and amputate the breasts of their women. Others again see in death, in suicide, the only hope. Sometimes a mystic will persuade others to join him, and a number of persons may agree to die together and may actually carry out their project. The method selected may be extremely barbarous and revolting. Thus, the patients may bury or immure themselves alive. Not longer ago than 1897 an incident of this kind occurred at Ternovo, Russia. A community of "old believers" objected to the taking of the census, a proceeding which they regarded as sacrilegious; rather than submit to this persecution, and led by one of their fanatics, they decided to die. They dug their own graves, which they entered alive, while one of their number, who had been charged with this duty, filled the graves with earth and stones. Twenty-five persons actually perished in this way. The member who survived, and who carried to its fulfilment this terrible act, failed to keep his own promise, for he lacked the courage to kill himself. Only a few years ago an incident occurred in Canada that was almost as distressing and certainly infinitely pathetic. A Russian colony, composed of a religious sect known as the "Dukbhors," under the leadership of one of their number, wandered over ice and snow, barefooted and bleeding, faint and famishing, seeking Christ in the wilderness. They knew that Christ was there, that they would see Him in the flesh, hear His voice, and that all their sufferings would be at an end. The Canadian Government was finally obliged to intervene, and to arrest this cruel and aimless pilgrimage by force. It must not be imagined that incidents of this kind occur only among Russian peasants; nor must we go back to the Middle Ages or to European countries to find examples of the baneful influences of mystic paranoia. It is not necessary to go back even as far as our own Salem witchcraft to meet with incidents equally terrible. In our own country, in our own day, with its boasted enlightenment and civilisation, a woman is allowed to die in childbirth, a child of diphtheria, a man lose his eyesight, a contagious disease to become epidemic, all because the relatives and friends of the patient are followers of a cult which denies the very existence of disease.

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"It is one of the unfortunate peculiarities of mystic paranoia that it frequently and very readily spreads, as we have seen, to other persons. Unfortunately every community, and especially the modern community, contains large numbers of persons of feeble mental resistance, of hysterical make-up, of persons who are morbidly vulnerable to suggestion. It is these upon whom the delusions are grafted, and it is they who in turn transmit them to others. It is interesting to note, also, that the hallucinations of vision and hearing are excited in a relatively small number; it is the naked delusions that are taken up by the masses."

There are so many points in common between the cases reported and this description, that the description might be said to be applicable. ~~All~~ ^{Both} ~~three~~ patients had a depressive or hypochondriacal phase, a transformation, and a period of expansion. Beliefs and hallucinations were of a similar nature to these described by Dercum, including beliefs of spiritual possession, hallucinatory communication with the supernatural, and beliefs that appear to be associated with genital hallucinosis. The histories show also the ease with which the illness spreads from person to person. The more distinctive features that the cases presented which are not described by Dercum are, the mildness of the depressive or hypochondriacal period in which the symptoms are not psychotic in nature, the acuteness of onset of the frankly psychotic symptoms, and the prominence of manic-like features in the psychosis. Dercum does not specify ages of onset as being different from that in other forms of paranoia, nor does/

does he say anything of prognosis. With regard to the prognosis of paranoia in general, he mentions the occurrence of "a distinct abatement of symptoms, "and even at times, though rarely, a clearly marked "remissionmore apt to be the case, when the "symptoms are relatively rapid in onset and course; "that is, when they approximate the acute form of "dementia paranoides."

Reports are now given of the first two cases. Both patients improved in hospital and left better able to deal with their difficulties of adaptation. The outlook in both cases is considered to be good. In view of the fact, however, that both have shown a great measure of instability throughout their lives, absence of psychotic symptoms is the most that is expected. In neither case is there any history of mental illness among relatives.

Mrs Jean Kerr

Aet - 28

Admitted - January 21, 1936.

Discharged - April 7, 1936.

In Hospital - 10 weeks 6 days.

Personal History

The patient's mother died when the patient was two years of age. When she was nineteen, her father and brother died within two months of each other. Shortly afterwards arrangements were being made for her marriage when she became pregnant and her husband refused to marry her. She was staying with an aunt, her only relative, but on account of the aunt's wishes she went into lodgings alone for her confinement, and the child was born within half an hour of the onset of labour without pain and with no one in attendance. Her husband paid her a visit soon after the child was born and apparently partly on account of a fancy he took for the child they were married a fortnight later. By this time she had lost all interest in her husband, was unable to understand his behaviour, and was convinced that she could never have any real affection for him. At present, although without real affection for him, she regards him with greater tolerance than ever before. She regrets her marriage even under the circumstances. There are three children. She states that on account of her husband's jealousy she "cannot speak to any men", and she has no/

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no close friends of her own sex. She has always been able to get on very well with people. She has been in the habit of doing her work with great energy, with a tendency to take up one piece of work after another. There have always been marked mood fluctuations. She describes herself as being accustomed to "soar up and crash". Her husband is very unintelligent.

Previous Physical Health

The patient had a tuberculous kidney removed at the age of eighteen. Since the birth of the first child when she was nineteen she has had a vaginal discharge and frequency of micturition, while the birth of the second child, when she was twenty-two was followed by prolapse requiring operation, and the birth of the third child, when she was twenty-five, was followed by puerperal fever. After the third child she was advised to have no further pregnancies, since when she has used contraceptives. Menstruation has been regular and normal. During the present illness the periods have been shorter than normal, until admission to hospital when she had a menstrual period of fourteen days with dysmenorrhoea.

Present Illness

In September 1934, sixteen months before her admission to hospital, the patient was introduced to a new form of religion by reading a book called "Healing/

"Healing for All". In this teaching she soon became absorbed and read everything about it that she could find within a very short time, devoting herself with all her energy to a study of this literature. She would often read it late at night instead of sleeping.

As part of the religious observance, she sent to the headquarters of the society at Bedford for small sections of "Holy Linen", made holy by "breath from the wings of the Holy Founder" of the Sect, and, putting this in water, the "Holy Water" was taken four times a day. After a course of this observance she wrote out a confession consisting of an account of petty thefts and petty lies in childhood, along with sexual difficulties in later life. This she sent to Bedford, addressed to the "Divine Mother", and received from there an assurance that the confession had been "received and voiced and accepted". As proof of this she was given a seal consisting of red paper saying that she agreed to live prepared to meet her Saviour. On receiving the seal she was permitted to observe "Communion" which was attended by eight people in Stirling in one of their homes. There were two sisters, who had been introduced to the religion a month before the patient, a single man and his mother, a married couple who were later introduced, and the patient and her husband. Communion consisted of drinking the water "sanctified by/

"by Holy Linen", of prayers taken by one or other of the two sisters - the Lord's Prayer, the Collect for the day, silent prayer - and of hymns, such as "Breathe on me, breath of God". The patient was very happy during the observance of this religion, and her physical health was better than it had been for ten years. The main difficulties that she had were when she felt that she was out of touch with other people, and that she had a knowledge superior to others but was unable to communicate it to them on account of being out of touch. Another difficulty was in connection with the religion itself - she felt that she was getting no direct instructions from the headquarters of the religion, but directions were sent to any one of the group in an irregular way. Doubts as regards the sincerity of the authors of the religion increased, and, more than a year after joining the Sect, she went herself to Bedford and interviewed the woman in charge who accused her of coming to spy on her and who told her that she would never find immortality. During the interview they faced each other with knees touching and the patient felt vibrations going through her as from an electric battery and she felt very frightened. This experience was sufficient for her to discredit the whole religion, the suspicious and brow-beating attitude of this woman being so unlike anything she had regarded as being saintly. On returning from Bedford, she was very distraught and continued to feel/

feel the vibrations in her body. One of the men of the religion came to ask her how she had got on and was told by the patient all that the woman had said. She felt the vibrations take hold of her at this time and everyone seemed afraid of her. She spoke with strange voices. One voice was soft and low, another was very powerful, and a third was a boy's voice speaking English with a fine Oxford accent, and this voice declared itself as "The Prince of Peace". Before this voice came she felt an upheaval in herself and was told that her face shone and was beautiful, and like a boy's face. The voice declared itself to be "the new spirit - the new created being", and the patient was just as much frightened as those around her. In another voice she said that she was the woman who would bear "the child". She spoke with these voices from eight till eleven at night, and after the people had gone away she heard a voice saying "Receive you the Holy Ghost", and she felt something like wind entering her womb. She was told by the voice that she would give birth to a child on the sixteenth of September. She remarks that it was believed that one of the women of the company would bear a "holy child", but the patient had never conceived of it as being herself. It was also told her that another woman would be in a trance in connection with the birth of the child. The speaking with voices and the hearing of voices occurred on a Monday night

(December /

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(December 1st), and then she continued to hear a voice during the week, although without any repetition of the dramatic circumstances. On the Friday night one of the women who led the religion in Stirling was said to have been "transfixed" and to have been speaking with Lucifer. She had declared that she was a woman who would encompass a man, that she was Jesus in a woman's form, that the patient was "the bride" and that they were married. It was on the same night in her own house that the patient threw her wedding ring into the fire, and refused to allow her husband to take it out. The following morning she met the woman who had been "transfixed" and was impressed by what she had said. Under this woman's influence she entered into a form of marriage with her, her husband and the woman's sister standing witness at this marriage. They changed their names, "taking the names of the tabernacle that they were to inherit." The patient was called "Sarah", her husband was called "Daniel", and the other woman was called "Rachel". The patient was quiet and peaceful for a day, and on the evening of the next day she "spoke of great joy" with a boy's voice, and thereafter a voice continued speaking to her at intervals - "either the voice of the Father, or the voice of the Son, or the voice of Lucifer who was the Son of the Morning and a part of the godhead" - the godhead being in four parts, the Father/

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Father, the Son, the Holy Ghost which comprised mother and daughter, and Lucifer. Lucifer thought that he was a life force in himself, was given a time to reign, but gave birth to no life and was cast out. Life was withdrawn from him and he is the moon which regulates that planet on which there is no life and no breath. This is an example of the content of the patient's hallucinations. She began to find the messages most confusing and even began to argue with the voices that she heard. On telling her story to one of the Sect, she was given the Life of Joanna Southcote to read. This story seemed to her most unconvincing and she began to persist in the attitude that she was not the woman who was to bear the child. She began also to have pains in the head explained to her by the voices as a process of being re-made, as part of which the brain was expanding. The voice frightened her and she tried to disbelieve it, and yet she found that it was true, for if the voice said that one of her friends would come and visit her at a certain time, then that friend would come. When she began to discuss her difficulties with her friends they told her that one could not believe in an uncertain voice. At times the voice felt to her as if her conscience were checking her and called her "my child". At times she voluntarily rejected the voice and she noticed that at these times she became coarser in nature/

nature, that she was rude to her friends and sometimes used oaths, whereas, under the influence of the voice, she was more saintly in nature. The conflict in her mind as to whether or not to give herself up to the voice reached a climax about the eleventh of January, about six weeks after going to Bedford. She spoke all night as if in delirium and thought that she was a Jew and that her spirit had been there when Christ was crucified. Previously, now and again, she had smelled strange smells - "evil-smelling", but that night she smelled very sweet smells. She thought she was dying. The next morning, by command of the voice, she drank her own urine. Either on her own instigation, or on the advice of her friends, the doctor was called in and he gave her an injection. Without this injection, the patient is sure she would have gone mad.

The doctor gave the following history:-

"I have known Mrs Kerr for over five years, and, until about eighteen months ago, she was one of my most regular patients. Her symptoms were always vague and indefinite, and I was always of the opinion that she was hypochondriacal. She read assiduously books such as "The Home Doctor" and always had her condition diagnosed before I saw her. Her third baby was born three years ago last month, and at that time there was no suggestion of mental disturbance.

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She developed puerperal fever then, however, but made a good recovery. Eighteen months ago she stopped calling me in, and was attending any other doctor from then until now. My next visit to her was about two months ago when I attended one of her children. At that time I remarked on her appearance of good health and she told me that she had joined a religious order called "The Panacea Society" and that her good health had been the result of drinking holy water provided by that society. I went and saw her on Friday of last week and then she herself sent for me because, she said, this religion had got into her brain and I had to get it out. It seemed that a doubt had arisen in her mind about the bona-fides of this Panacea Society, and on investigation she had found it to be a false faith. Since then she has had an hallucination of a voice which bids her to do things and which she must obey; for example, it told her to drink her own urine and this she did. At first I thought that she was in a condition of hysteria, but after seeing her daily since Friday, I fear that her condition is worse than that."

The friend who entered into the marriage service with the patient was interviewed. She relates that she and her sister had always believed in "British Israel" and that their mother had believed in it all her life. It was in a following out of this belief that she joined the Sect and came into/

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into contact with the patient. She regards the patient as a very clever woman in unfortunate circumstances who is unhappy with her husband who is very ignorant. She corroborates the patient's history in its entirety. She states that she herself is a nervous and emotional kind of person, but during the interview she gave the impression of being intelligent, calm and rational. She is of a better social and educational standing than the patient.

About six months before the patient's admission to hospital she and her sister began to have doubts about this religion. They went to Bedford, and on returning stated that they had no further use for it and severed their connection with the Sect. The patient, however, was much disturbed by this lack of faith, and the sisters felt that they were to some extent responsible for her disturbance of mind, having regard to their better social standing, and to the fact that they were in the religious Sect before the patient. Eventually they arranged for the patient to go to Bedford to be disillusioned herself, thinking that this was the most rational way of clearing up the patient's difficulties. When she returned, however, this friend visited her and was quite carried off her feet by the patient's appearance and witness. She tells how the patient spoke with different voices and admits that she was completely/

completely convinced of the absolute truth and validity of everything the patient said, and that when she spoke with a boy's voice her face shone as if illumined inwardly, and to some extent this friend shared in her ecstatic experience. This spiritual partnership remained during the week when on the Friday night the friend felt herself under religious influence, and during the marriage ceremony on the following day says that she was quite as much involved in the strange line of thought as the patient. Within a few days, however, things seemed normal to her again, and she was greatly perplexed with regard to the experiences she had gone through. Thereafter her attention was occupied by wondering what was the best thing to do with regard to the patient. During the few days when the patient was worse, before being admitted to hospital, this friend stayed with her.

The only point in which the patient's story is not corroborated is that she says that she was the first to doubt the religion. One of the points which has disturbed this friend very much since the acute stage of the patient's illness, is the difficulty in disbelieving the patient's inspirations in view of the fact that the patient has shown an unusual ability to see into other people's lives. For example, she has been able to give the friend an account of the details of her conduct when they were in widely separated places.

In Hospital

In hospital the patient gave the impression of being a keen, active, alert little woman. Her behaviour was marked by restless activity. There was pressure of talk which was coherent and relevant. There was no withdrawal of interest or lessening of affect. Her prevailing mood was one of happiness within normal limits, although there were times when her attitude was co-operative. She was always very neat in her appearance, and one of the other patients was heard to remark that when she walked in the street she thought that everyone was taking special notice of her.

She gave a complicated system of beliefs which is contained in the teaching of the Bedford Sect. She retained faith in the validity of the beliefs as part of her religious life. The hallucinosis diminished in hospital. At times it seemed like an external voice, at times like an inner voice, as if her conscience were speaking to her. The voice was present when she prayed. It was kind and gentle and she thought it was a man's voice. She thought it might be due to her subconscious mind repeating things it had heard and seen. It spoke of religion, apparently elaborating the Bedford teaching. It sometimes admonished her, for example: "You were doing very wrong - you must tell everything". She realised that she had been mentally ill and unable to control her thoughts, thinking she/

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she had got over this illness and that it would not recur. She blamed her friends for believing in the religion and asked why they had not seen that there was something wrong with her and why they had believed her when she said such things as she would bear a spiritual child.

Only on one occasion in hospital did she give any sign of speaking with voices. She was sitting on another patient's bed alone with her in her room. They were discussing love when the patient's face was said to be "transfigured", to shine with a light, and her voice to become a boy's voice. This was the impression of both patients. Again, during the night she once woke up and felt that her face was shining. She disliked these experiences, as exhibiting morbid trends in herself. She wondered whether there were anything unusually masculine in her to account for her speaking with a boy's voice.

Physical examination was attended by anxiety symptoms on the part of the patient. When her pulse was being taken she complained of severe throbbing in the upper abdomen, vibrations throughout the whole body and a sense of impending disaster. She was hyperaesthetic, showing evidence of great pain when the blood pressure was being taken. She refused investigation of the genito-urinary system by a gynecologist, apparently having a horror of it.

After physical examination she could not be interviewed/

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interviewed for some days on account of exhibition of fear. She was apprehensive that she might be afraid of her husband when she returned home, and adds that the interest in religion began with a fear of death. In her religion, stress is laid on the immortality of the body, rising in perfection. She has been disturbed by the thought that after the present illness she might give up religion altogether, and particularly disturbing would be to give up belief in immortality. In hospital, when insight increased and hallucinosis diminished, she became more preoccupied with her physical health and had a new horror of instruments and operations. It is doubtful whether hallucinosis had entirely disappeared before her return home. She went home within three months.

Physical Examination

Physically she gave the impression of being of rather a boyish type of build. The only abnormalities found on examination were two abdominal scars, tenderness on deep palpation of the abdomen along the line of the aorta, and a pyuria which cleared up satisfactorily.

After Leaving Hospital

A letter, written six months after she left hospital, is as follows:- "I am very sorry to be so long in answering your letter, but I do not know what to say because I have been very well since leaving hospital and much more contented with life. I have never/

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never given religion a thought, but one of these days I will start going to church like everybody else. I may also add I am expecting another baby in the Spring and hope everything will be all right this time. So far I have been very well."

John Muir Paterson

Aet 31

Admitted - November 29, 1935.

Discharged - December 28, 1935.

In Hospital - 4 weeks 3 days.

Personal History

As a child the patient was reserved and shy. He describes himself as being very timid and over-awed at school, and he always felt very self-conscious and afraid in the presence of anyone in authority. On leaving school he took up work as a druggist. In his first job he felt that he was being given all the dirty work to do and felt an object of derision, just as he had been at school. These feelings made him angry and on one occasion, at the age of fifteen or sixteen, he threw something at his employer and was sacked. For fifteen years thereafter, until the present illness, he has been with the same firm, and has apparently done his work satisfactorily, rising to the position of branch manager. He was best as a salesman. During these years, however, there were times when he felt very inadequate for his work. At the age of twenty-seven, four years before the time of the present illness, he took a course in Pelmanism. He usually felt self-conscious in company, had little social life, and did not make girl friends.

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So far as an objective estimate goes, however, it is probable that he was considered to be quite well adapted to work and family life.

History of Eighteen Months

Before Onset of Illness.

A year and a half before admission to hospital, when he was thirty, the patient was off work for three months "on the verge of a nervous breakdown". He had a fear of insanity. He thought that his increasing self-consciousness caused him to act strangely and he thought that others took special notice of his unusual behaviour. Thoughts were rushing through his mind at a terrific pace, and on account of this he was unable to sleep. One night, about midnight, he "gave himself up to God", and had a feeling of relief and satisfaction and was freed from all troubled feelings. He told the members of his family that he had found salvation. His knowledge of salvation, however, did not last very long, and the fear of insanity returned. He appeared to make a good recovery within three months. A few months later he saw a course of lectures in psychology advertised. He began this course of lectures and four months later he entered on an advanced study course. He was accepted by the lecturer as a pupil for training, and intended to complete the study course in order to/

to become a lecturer and to devote his whole time to the preaching of the special doctrine that he was learning. His closest friend was being treated for nervousness by the lecturer at the patient's expense. The advance course of lectures, mainly by correspondence, cost him £30. During this time he continued his work as a chemist, but with great dissatisfaction, having little faith in the drugs he was selling, his mind being occupied by loftier and more spiritual thoughts. He is unable to give an account of the teaching, having promised not to divulge the secrets of the group or to let anyone see the typescript correspondence course. The lectures themselves lasted a fortnight in the year. There is a small book, however, which gives the more elementary part of the teaching. It is arranged in exercises of which these are examples:-

"As you breathe in, repeat the following about twenty times - I am breathing in creative life which is now circulating freely throughout every artery of my being.

As you breathe out, repeat this statement of truth - Subconscious mind, you are now dissolving and expelling all that is diseased in my body.

After a few minutes, as I have explained in Lesson III, the subconscious will become very receptive. Now is the time to drop in true thoughts./

thoughts. Then repeat, slowly and with feeling, the following, which is simply a statement of the true facts of life - I am a conscious centre of the one infinite life and mind. I am Health, Strength and Power."

Another example is the following:-

"Become perfectly still and quiet and relaxed. Stop thinking altogether of your troubles or of any physical disability. Just repeat the following about twelve times - I am part of the infinite mind power, a conscious centre of life, love, truth and beauty. That power now finds perfect expression through me in my personal life."

Much of it is repetitive. For example, we have again:-

"As a centre of infinite mind power, I now open myself to the abundance of all good. I affirm that all good things are flowing to me now from the infinite source of abundant supply."

The patient dedicated himself to the teaching of this psychological religion and had great happiness on that account. He found he had great insight into the nature of man and the universe. He found himself unable to take any part in ordinary religion on account of his greater knowledge.

History from the Time of the Acute

Onset of the Illness

The acute phase of the illness began abruptly during/

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during the second fortnight of lectures, a year after he had first entered on a course. His father describes the onset as follows:-

"John's landlady told me he was off food for three days, and John's chum, who has been in poor health and depressed for some years, told me John had been at lectures every night that week. He seemed worn out that night and his chum wanted to go home with him, but John ran away from him. His chum told me that from where he left John, and from where he was found, it seemed as if John had been making for Mr Goddard Smith's (the lecturer's) lodgings. The policeman found John with his clothes off and in a dazed condition. He took him to Glasgow Western Infirmary. John told them there he would not answer any questions till they brought Mr Goddard Smith, which they did not do. I arrived at the Infirmary at 12.30 in the morning. I shook John and asked him what was worrying him but he said I would not understand. I asked him if he was remembering it was his sister's wedding night, and he said - "Yes, and I've spoiled it". I left him then as he was dazed, and returned at 2 p.m. As he was sitting up, I got permission to take him home.....John danced at the wedding and enjoyed himself, but felt a bit done at the finish..... He was almost normal till Tuesday (from Friday).

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On Tuesday he turned on the wireless at eleven and kept it on till four. Then he got up and dressed. The next two days were taken up with listening to the wireless and gramophone, writing letters, wiring Mr Goddard Smith, and seeing his doctor and minister."

He told his father he was going to do away with himself, as everyone was against him. He told him also that he had been made an offer, over the wireless, of three thousand pounds for his knowledge. On the third day, a week after the acute onset of his illness, he was admitted to hospital.

One of the letters he had written was as follows:

"Gentlemen of the Police -

Friends, I desire to acknowledge all messages received this afternoon. Will you please convey my sincere thanks for all the kind words and thoughts expressed. At the moment I am too overcome to write a long letter. The music was delightful, and I have never spent a day midst such luxury. Please be kind and send only a little fruit at a time. The same applies to flowers and hot-water bottles. Think for a little, as I have done to-day, of all the people who are confined by some kind of illness in hospitals and institutions all over the kingdom, and if you have a little to spare, send it to them to-morrow morning with my love as well as your own. Then remember the children. Think of yourselves to-morrow, not as men/

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men and women, but as fathers and mothers, brothers and sisters, uncles and aunts, and so on ad infinitum. I am sending my messenger to you to-morrow for an article I value very much. It is a cigarette lighter, and the messenger will help you to recognise it. Please look after him well and see that he catches his train in extra good time. I desire to thank those constables and others of the police who so kindly looked after me all day on Friday. I wonder if you would be so kind as to present each of them on my behalf with twenty-seven new shillings each. The numbers 2 and 7 are rather wonderful when you come to understand them. The 2 stands for loyalty, patience and steadfastness to duty, whilst the 7 is the number of philosophy and carries with it all the wisdom of the ages. The two numbers combine to form the one unit which is the number of universal brotherhood and service to all humanity, and to-morrow being the 27th the day will hold special significance, as the number 1935 also totals up to 9.

May I close with a little leg-pulling. I think it is essential that the Force should be looking its best to-morrow afternoon, so will you please see that each man from the rawest recruit to the Chief Constable takes a pill to-morrow morning at nine o'clock. I know how out of sorts one feels if one is/

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is constipated so remember to make it a number 9.

Yours very affectionately,

JOHN.

P.S. This letter is open. I am sorry I am not much good at geography, but I know the world is round as a whole. Let all the stations tune in to-morrow to Edinburgh by 3 p.m."

In Hospital

In hospital the patient was restless, over-active, and frequently in a state of considerable excitement. For the most part there was pressure of activity and pressure of talk. Flight of ideas was in evidence. The prevailing mood was of elation but great resentment was sometimes shown. At times he was very co-operative, and at such times he would talk without ceasing and with emphasis, as if addressing a public meeting, while questions were answered diffusely and not always with relevance. At times he was antipathetic, and on one such evening he refused sedative and for the greater part of the night sat upright in bed staring in front of him without much sign of agitation. He spoke of a strange experience which occurred if he went to sleep with his hands and feet in contact. He felt that he breathed fire and that light shone from his eyes. There was a sensation of abnormal activity/

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activity in the lower abdomen and he felt that a spirit was being generated in him, and he spoke once in this connection as if he felt that this generation in him was in the form of twins. As regards his beliefs he said that for the previous fortnight he had been recognised as Jesus. A gentleman on his right put his hand on his. Two priests also recognised him that night. He gave the following account of his being found naked:-

"I expected to see the vision of John when I crucified myself. Under the Kelvin Bridge I stripped naked and stood on the damp ground and outstretched my arms and crucified myself. I did this because of a lecture I heard from Mr Goddard Smith. There were witnesses to my crucifixion and they said - "He'll catch his death of cold, the damned fool!" I then collapsed in their arms and this was my cup of vinegar."

When he attended his sister's wedding, just at the close of the wedding, he looked out of the window and saw a flash of light, and then looked at the pavement and saw the letter Z. "The letter Z", he says, "is the symbol for John, and has the significance of Omega. I am quite sure other people saw the same thing although they made no pretence to having seen it."

He also spoke of marriage:-

"The marriage of which I spoke concerns more

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a spiritual marriage. I chose for my sweetheart a young man. My idea was to instil into man, force of a loving nature. Men are not so understanding or so loving and it is our duty to equalise the sexes so that man must be more loving, and then there will be heaven on earth. Eventually there will be no need for the sexual act, for those that are dead will come back."

He had abundant ideas of reference. For example:

"In every little saying I can see some meaning. There is an arrangement throughout the world regarding me. I know that through the wireless my thoughts are being tapped."

He had the idea that he had great power. By moving the clock in the centre of the table, he could move the clouds or turn them into gold. His mood could influence the weather. He could influence the size and position of the moon by manipulating a certain mirror. He had been called to work of vital importance to the whole world. When he looked at the clouds they would turn a golden colour, the colour of the sun, and would gently float away.

After a week in hospital his thoughts, he said, were more orderly. By having his thoughts more in order he seemed to mean that he was finding more connection between one thought and another. Everything, for example, could be connected with letters. A stood for the sales manager in his shop, B for the general/

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general manager, and so on, the other letters mainly standing for different branches. Bathroom, again, suggested home, and his brother is in an iron-mongery business and makes grates, and this brother was with him when he had a moment of exquisite happiness, when he gave himself to God; and so, by one thing leading to another he is getting his thoughts into order.

After being in hospital for three weeks, he wrote a letter saying that his thoughts were now all in order, that he had been ill and had recovered, and that the important thing for him was to have a holiday and then to return to ordinary life.

He left hospital after a month. His behaviour was normal, and so far as could be ascertained, he had no delusions. He was calm in his demeanour and there was no flight of ideas, irrelevance of talk, or similar abnormality. The patient's father was glad to take him home. He had little idea of the seriousness of his son's illness and thought it had been a mistake for him to have been in hospital. He was set in his opinions and was not prepared to be advised.

Physical Examination

Physically the patient was of an asthenic habitus, of effeminate appearance, and had a high pitched voice. There was no evidence of any disease.

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After Leaving Hospital

The patient was interviewed ten months after leaving hospital. On returning home, he had had a holiday and felt better, but was flung into the depths of depression when he found he was not getting his job back. He tried to get into touch with Mr Goddard Smith whenever he got home and he paid him some money. There was some correspondence, but Mr Goddard Smith did not comply with his request for a personal interview. Since then, for ten months, he has been staying at home, except for six weeks when he had a job as locum in a druggist's shop in another town and he seems to have done this satisfactorily. He has apparently shown no evidence of any unusual thoughts or behaviour. He has been prevented from applying for work on account of feelings of inadequacy, and fear of an interview with anyone in authority such as an employer or manager. His people have persuaded him to keep away from psychological meetings. He retains his belief in the religious truth of the psychology he was taught and he is still unable to take part in a church service on this account. Once the main part of the religion is grasped, all else is clear. It all fits in. It is realised intuitively that it is true. The main part of the realisation that we must grow in oneness as part of the one life which is seeking to express itself through us, the one life/

life being God. He was not asked about his belief that he was Christ, but a question on these lines had been put to him before he left hospital and he said then that we had all the Christlike in us, as Mr Goddard Smith explained in his lectures, and that - to borrow a phrase from Mr Goddard Smith - he was "so much in tune with the infinite" that he was expressing the one life, the Christ life, there being two lives in us - the carnal (or old Adam) and the Christ life.

He is still leading a lonely life, though he gets on well with his family circle and sometimes can take part in social life. He is liable to feel self-conscious on such occasions, and when he feels that people are looking at him, or if he feels conspicuous by reason of feeling self-conscious, he is troubled by palpitation and sweating and has nervous mannerisms. A few weeks later he was interviewed again and expressed the wish to be a male nurse in a mental hospital. He felt that he had no outlet for his feelings, that he was always being rebuffed, that he had no outlet for his affections, and that only in the atmosphere of a mental hospital would he have a feeling of relief. To have such a job would be the logical conclusion to his thinking.

Further History

The RELATION of the DELUSIONS in the
FOREGOING CASES to the LIFE SITUATION.

The first question that will be dealt with is the significance of the delusions in relation to prognosis and this will be done by ascertaining to what extent these delusions bear a resemblance to the prepsychiatric beliefs, to the beliefs of the people with whom the patient associated before the onset of the psychosis and to normally accepted beliefs. The main point with regard to the delusions in relation to prognosis is this: To what extent were they the result of environmental suggestion and to what extent an expression of a compensation for an individual maladaptation without regard to social requirements of adaptation and the beliefs of others. If they are to some extent the result of the suggestion of others, as seems apparent, then they might be said to partake of a "hysteroid" element.

There is a footnote in Hoch's book with regard to the historical records of mystic episodes: "Many of these states seem to be hysterical rather than maniac depressive stupors, but so far as the unconsciousness goes there is probably as much psychological as symptomatic resemblance between the two types of reaction".

Dercum /

Relation to Hysteria

Dercum refers to the occurrence of rapid spread of mystic paranoid ideas, and the formation of groups on the basis of acceptance of mystic delusions. The first case is an example of an individual in such a group. Such delusions, according to Dercum, are most likely to spread in communities containing large numbers of persons of feeble mental resistance, of hysterical make-up, of persons who are morbidly vulnerable to suggestion. It might be concluded that those showing features of the hysterical personality are most liable to be affected. The possible relation between this group of psychotic cases and hysteria must therefore be gone into. The differential diagnosis between hypochondriacal complaints occurring early in the course of a paranoid reaction, and complaints which represent conversion symptoms in a hysteria may not be easy, and in the first case it would have been difficult, at that stage, to decide which the patient was suffering from. With regard to the expansive phase also, the possibility of hysteria may have to be considered in view of its reported occurrence as the result of suggestion.

In two of the cases, friends were involved in the psychosis, in the first instance under the patient's influence.

Mass/

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Mass hysteria is a more frequently used term than mass paranoia or mass schizophrenia. Kinnier Wilson describes how the forms of hysteria vary with current belief and medical ideas, recounting the various vogues of hysterical practice, including the mediaeval ecstatic and demoniacally possessed, the invalidism of Victorian resorts, and the present day forms of neurosis, making particular mention of compensation cases. The divinely and satanically possessed may have had a similar relation to the thought of the day in mediaeval times that spiritist mediums have to present day thought, and are generally considered to indulge in a flight from reality in the form of a hysterical dissociation rather than to be suffering from a frank psychosis. Even to a greater extent is this the case where the individual believes in the delusions under the influence of another's suggestion. The quack, the spiritualist teacher, the Negro "God", or the Führer may have inspiration which depends on a truly paranoid strain, but the followers could perhaps be better described as hysteric. They lack the distinctive features of mysticism, the qualities of direct experience and of incommunicableness as described by William James - "Mystical truth exists for the individual who has the transport, but for no one else". Nevertheless, where patients are concerned, it may be difficult to judge the extent to which an experience is directly/

directly and intuitively "felt", and the extent to which it is the result of human suggestion. The difference may be one of degree. It is a question whether the difference between a hysterical dissociation of a mystic nature, such as a medium might be subject to, and hallucinatory episodes, such as the first patient described, might not also be one of degree - the difference being in the extent to which it is the result of external suggestion.

Relation of Psychotic to Normal Belief.

If delusions can be the result of external suggestion, their relation to normal human beliefs becomes important. In discussing the prognosis, the importance of the patient's capacity to relate his delusions to current beliefs will be discussed. A delusion is an article of personal belief and the difference is one of social acceptability rather than of inherent character. Joad describes belief as follows:-

"The only test of a true belief now becomes the pragmatic test of its ability to satisfy the wishes which led us to form it. Since a belief which has been satisfactory in this respect in the past may cease to be so owing to a change of circumstance, or in the unconscious wishes which led to its formation, no belief can be more than provisionally /

ally and temporarily true". This does not exclude delusion from the definition of belief. The question that arises is: "How is current belief to be judged?" If the delusions are to be related to normal belief what is normal belief? Beliefs in the Capernican system in astronomy and in evolution are presumably part of normal beliefs but there are large numbers of beliefs held only by a section of the community or a minority sect. Since the delusions of our patients are so closely associated with religious beliefs it may be worth while to digress on the subject of beliefs in order to examine present day beliefs and the nature of present day tendencies in belief.

~~delusion from the definition of belief.~~

Macfie Campbell's book on the subject is taken up with the importance of the balance between the adequacy of a personal belief for the individual and the acceptability or sanity of the belief which seems satisfactory to him. It would be helpful to know what beliefs are socially acceptable or "sane". Macfie Campbell has explored the negative side of this question in discussing a number of beliefs of varying degrees of unhealthiness, and reflecting as to whether the wishes which led to the formation of these beliefs could not be satisfied by beliefs of more general acceptability. The positive question is, what constitutes healthy belief, and what are the standards for judging the comparative sanity of a patient's statements? The validity of mystic or religious beliefs need not be gone into. It is clear that religion depends, to a large extent, on the fact that the realities of human existence have been laid hold on and appreciated to such a clear extent by people who were otherwise abnormal. The life of George Fox provides a convenient example.

Similarly, Nijinski provides an example of a case where a sure hold on the realities of artistic expression were associated with apparently malignant psychopathic tendencies, the inspiration which led to his perfection being the same which led to his psychosis. "Art", he says, "is not an imitation of/

"of nature, but it is the image of nature obtained through artificial means", and in holding up the image of nature he expresses the true schizophrenic character: "Nijinsky contradicts the classical position by making all steps and gestures turn inward". His psychosis, beginning at a similar age, has something in common with these cases. His pacifism was of the Christlike kind, as was his refusal to have two meanings for the word love, as is shown in his retort to Isadora Duncan when she questioned him on marrying after refusing her advances - "I did not change..... I love everybody as Christ did."

If George Fox had lived now, he might have been living in an asylum, and would not have founded the sanest religions sect in Christian history. Similarly, Nijinsky, in former centuries, might have developed his mystic powers for popular acceptance.

These are only further illustrations of the well worn thesis that the comparative sanity of belief is measured by its acceptance for the day. The converse also holds - that the kind of insanity varies with the thinking of the day.

It is difficult to find a clear and authoritative expression of present day belief to serve as a standard for comparison. The clearest authoritative expression of religious belief published in recent/

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recent years in this country would appear to be a series of lectures of four Scottish divines delivered in 1894. This consists of a reasoned declaration in favour of belief in the miraculous in the Christian religion. The lectures constitute an attack on the more sceptic outlook of Professor Pfleiderer of Berlin. Belief in the truth of all kinds of miracles in the past must therefore be accepted as reasonable since the beliefs of a liberal group of divines is likely to be an index of popular faith for some decades.

A growth in belief in telepathic communication among people of sceptical outlook is an outstanding feature of modern thought. Spiritualism, or anything else demanding more credulity than beliefs in telepathy or in the miraculous recorded in the New Testament, must be regarded as belonging to minority groups which may be supposed to attract persons of psychopathic type, the saner minorities at the present time being sceptic rather than credulous. At the same time, it is well to note that the outlook of the majority of people at the present day may be tending away from, rather than towards, more rationalistic views. Prominence is given in the middle page of an evening paper, for example, to the claims of a psychic healer, one of the paragraphs reading as follows:-

"...From another patient, a woman, Dr Wickland said/

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"said he had dislodged thirteen 'interfering spirits', seven of them being recognised by the patient's mother, by other members of the family and a minister of the church."

Although this is an extreme instance of publicity being given to strange views, Buchmanism alone provides sufficient evidence of the growth of irrational views in religious practice. This tendency in religious practice is parallel to the tendency in authoritative theological thought. The liberal theologian's idea of God is put by Seth in 1897 - "This authority, claimed and exercised by the higher self, is only intelligible if the ideals of that self are recognised as the immediate presence within us of a spirit leading us into all truth and goodness. The moral law is not first imposed by the individual self (in the theory of ethics) and then ratified or re-imposed by an external lawgiver (in the theory of religion). Rather the two are one from the beginning. God is the source and author of the law, but only in the sense that he is the higher self within the self which inwardly illuminates all our lives."

This view, which would appear to be eminently acceptable by modern psychologists, is in striking contrast to the pronouncements of the present day leader of theological thought which are precisely of the transcendental variety which Seth seeks to get away from. A logical result of a reaction in favour of transcendentalism would be a revival of beliefs/

beliefs in apocalyptic ideas and of interest in otherworldliness generally.

The following is an illustration of irrational tendencies in belief, taken from a report from Japan:-

"The tradition of the descent of the Japanese ruler from the Sun Goddess has seen a strong revival during recent years. Ten or fifteen years ago liberal Japanese leaders were inclined to interpret this tradition as meaning only that the line of Emperors, to quote the constitution, "is coeval with Heaven and earth", leaving the attendant mythology to fade into the background. Others even professed to hope that Japan would develop into a constitutional monarchy of the British type. To-day, however, no one dares to express such opinions openly..... It is forbidden to refer to the Emperor as a man even in praise, and most Western journalists adopt the policy of referring to His Majesty as seldom as possible in order to avoid giving offence. They dare not ever refer to the Emperor Meiji as a "truly great man". Japanese express amazement that Christians should be so foolish as to believe that one person (Jesus) might be both human and divine."

The alterations in ideas with regard to authority in politics is a significant parallel to the change of view with regard to authority in religion./

Stanley Casson, in his book, Progress and Catastrophe, draws a parallel between reaction in present day thought and reaction at the beginning of the middle ages. The relevant paragraph is quoted in full:

"The only peace for the citizen of Constantinople was to be found in his churches, his liturgies and his ceremonies. Man fled once more, as once in Egypt, for comfort to the unknowable in order to defeat the unknown. Religion thrived as never before, because it comforted. Intellectual comforts are poor nutriments for men facing the horrors of immediate war. So to-day, the long drawn threat of international war has led to the growth of wholly unintellectual forms of religion, strange fervours of irrational enthusiasm, organised by the unintellectual for the weak-minded. Strange sectaries, Buchmanites, Anglo-Israelites, countless other cults, now batten not so much on stupidity pure and simple as on a lack of desire to use the human intellect for its proper purposes. And that weakness comes of fear. So the Byzantines fled to the comforts of religion."

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religion.

This brief review of tendencies in present day thought is introduced on account of the necessity to review current beliefs from time to time in order to have a clearer idea of the extent to which morbid beliefs vary from beliefs of general acceptance. It would appear that the present tendencies are towards an increase rather than a decrease in belief in the miraculous. Frankly expressed apocalyptic beliefs can fairly be said to be outside the range of the orthodox, but these beliefs are at present widely expressed in variously modified ways among normal people. Increasing transcendentalism in belief naturally sanctions the acceptance, in some form, of the miraculous and the apocalyptic. The psychopathology of such beliefs, however, must be similar whether the beliefs are held in a modified form and timidly expressed among religious people, or frankly declaimed as they were by these three patients. It would appear that, looked at in quite a superficial way, there is a clear association between the patients' ideas of the miraculous appearance of Christ, and a renunciation of sex and a denial of its necessity for procreation, in accordance with the expressed ideas of the evil of sex and the possibility of parthenogenesis and androgenesis. The manic features are no doubt related to the adequacy of the delusions in the attempt to overcome feelings of guilt in relation to/

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to the sexual.

Renan gives a similar interpretation of early Christian beliefs holding that the Christian Church was founded solely on the early expectation of apocalyptic intervention and that the spiritual exaltation was associated with a renunciation of sex, its necessity being denied in view of the apocalyptic beliefs.

The conclusion may be stated that in studying mystic states there is found to be no clear distinctions between delusions which are paranoid in character and beliefs which are hysterical, owing their origins to suggestion and that there is no clear distinction between the morbid and the normal. It is important, however, to assess to what extent a patient's symptoms are the result of suggestion and to what extent they approximate to the normal for which purpose a knowledge of current trends in belief is necessary.

Thomas Kaye Dougall. Admitted aet. 28.

There is no family history of mental illness or instability. Delicate until the age of seven the patient had been extremely healthy since. He went to the University at 17 and was medallist in his honours year at the age of 21, after which he held responsible posts in which he gave complete satisfaction until the sudden onset of mental illness. Essentially of a studious nature, he engaged to some extent in sports, especially in golf, and went on walking tours. Although said to be rather shy, he mixed freely in company and had friends of both sexes. He contributed articles to literary journals and had taken some interest in politics. Although not aggressive he had plenty of self confidence, and speaking in public did not make him nervous. He was not moody. He had been specially friendly with a girl sometimes referred to as his fiancée.

Six months before admission to hospital he had been upset following publicity on his gaining first prize at a verse speaking competition. He is said not to have regained his usually buoyance after that.

Eight days before admission he complained of something compressing his brain and after a game of golf is said to have been confused. Two days later he went home and is said to have talked nonsense. The next day he left to visit his girl friend as previously /

previously arranged. The following day he said that he had to go on a mission, that he had a message to proclaim to the public. He went to the middle of the street though no-one was about and made a short speech on the theme, 'God is love'. He insisted on returning to his work but on the following day set out to walk south to proclaim his message and was with difficulty followed and brought to a mental hospital where he was detained under certificate. Three days later when asked whether he would return to his occupation he said that first he had to proclaim his message and that he would wait for orders from the voices. He constantly tried to escape, in order to make public speeches. During the next seven months he was variable, frequently listening to voices, answering them, and arguing with them. He was at times very apathetic. Towards the end of this time, although it was the medical opinion that there had been no change for the better, he was fairly easy to manage, was anxious to go home, and his sister believing that he was back to normal, he went home. As soon as he went home he became worse and more withdrawn, rarely leaving his house. Apathy increased and for the eight months that he was at home he spent most of the time in bed. A week before re-admission he complained of frontal headache and became restless. He packed a trunk and made to set off from home, but was prevented. For the following two /

two days he came downstairs with no clothes on. During his period at home his apathy had been punctuated by outbursts of laughter, periods of dictatorial conduct, and he continued to hear voices. He believed that his mind was broadcasting and that other people could read his thoughts. From the time of readmission he remained in a condition of catatonic stupor, with *flexibilitas cerea* and bizarre postures especially kneeling to pray, and curling up under his bed. He wrote letters to Mussolini, Bismarck, Hitler and the Pope in terms of adoration. The letters are typically schizophrenic documents showing incoherence, irrelevant high sounding phrases, and crude symbolic drawings. Overt homosexual interests have necessitated the patient having an attendant constantly by him. The duration of his illness has been four and a half years.

Another case can be given where the proportion appears to be had in proportion to the "loneliness" of the patient in her mental life. Although the illness began with a mania, this was followed by a stupor which in turn was superseded by katatonic excitement and the patient remains in a mental hospital two years after the onset of the psychosis.

Her mother died at her birth. At the age of six months she had a mastoid operation which left her with a severe facial hemiparesis and this deformity has coloured her entire life. In her psychosis she made frequent remarks with regard to the shape of her mouth. /

mouth. It is perhaps of interest that in her life, which has been one long attempt at compensation her main interests might be considered to be compensating oral activities, namely cooking and taking an interest in religious meetings of the more extreme evangelical sort. The patient was made a great deal of by a stepmother who died when she was six years old. During her childhood she was self-important, self-willed, not very truthful, and described by her father as of a "twisted" nature. At the age of 18 her nature is said to have undergone a change for the better when she experienced a religious conversion. A letter written about this time to a friend is of the most extravagantly evangelical nature and indicates that the patient's entire emotional life was centred round her interest in Christ.

In the summer of 1935, a year before admission, the patient was home for a holiday and was then regarded as quite normal. The first change that was noticed was that she sent no money home for her people to bank from September 1935 till January 1936. During that time her letters began to have suggestions that she was to be married and she said that a certain minister wanted to marry her. There were strange laconic remarks such as "You'll hear more anon!" Her people had never thought of the possibility of her marriage on account of her deformity. Her people depended on the mistress in the school where she was working /

uld

Additional History (cont.)

at a certain minister wanted to marry her. There were strange remarks such as "You'll hear more anon!". Her people had thought of the possibility of her marriage on account of poverty. Her people depended on the mistress in the school who was working as a cook to let them know if anything were with her and it was not till January 1936 that her father was found and found her grossly disordered so that there was great difficulty in getting her home. She was restless, elated, talkative and excessive in a grandiose way. For example "There are your papers - you're an author. That's your article!" There was improvement within a day or two of her arriving at home. Gradually without becoming elated again, she became rather irascible and difficult to get on with and independent and aloof. She did things differently from others. In drying dishes, for example, she slowly dried them and put it away in the cupboard. After she had been at home she said to her father "Daddy, why don't you let me marry ...". Her father told her he had no objection but he hadn't seen him and he hadn't seen him. She said "Oh yes, he's been here", seemed puzzled. During the next six months she was in bed the part of the time, was going down in weight, was removed from life and, at times as on admission, quite stuporose. It has been mentioned that the patient underwent a religious conversion at the age of 19, two years before the onset of the psychosis four years before admission to hospital.

Examination of the patient on admission to hospital was ~~DE~~
as follows: 176

Mental Examination

Patient has a mask-like expression, the skin is un-
der, glossy and pale. The eyes are completely expressionless
like one of artificial eyes, and the lids droop. The usual
posture is with the head bent and a general flexed attitude of
the neck and the upper limbs. This is not associated with a flaccidity
but with a certain rigidity. There is a pronounced katatonia.
The limbs can be put in any position where they will be retained
rigidly. There is a coarse tremor of the arm and hand sometimes
marked, and a shakiness of the lower limbs sometimes evident on
walking. There has been incontinence of both bowel and bladder.
The patient frequently sits without any expression or understanding
of questions or remarks. Occasionally she will reply by a smile and
when she smiles it is usually impossible to get her to engage in con-
versation. Sometimes she will be slowly induced to answer questions
in which it is apparent that she has very good understanding of what
is said to her. She is perfectly well orientated as regards place,
time and person. Her memory is good and accurate. Her general
intelligence is intact. She speaks very slowly and will often be induced
to say only a few words. She does not reply to any complicated
questions and her best reaction is to short comments - for example
when asked to open her mouth or to answer a brief question. In the physical
examination her reaction time to the sharp and blunt instruments was
good.
She describes how she has a heavy feeling as if her whole body were
drawn down to her feet. It has not been possible to get an insight
into whether she experiences difficulty in thinking or speaking, or into
the nature of her mental processes. She can be encouraged to converse
on general topics but not on her illness.

Miss M. Auld

Progress

12, 1936 After three weeks in hospital ^{the} this patient's ^{was} ~~condition~~ is not quite so limited. She ^{felt} feels that she ^{was} is apart, ^{was} things are unreal. She has ^{felt} headache, ^{felt} feels tired and stiff. ^{felt} she feels indifferent to things around her and with regard ^{felt} self ^{felt} feels quite indifferent but more usually she ^{was} is sorry for ^{was} ~~There~~ is no evidence of delusions. She ^{had} has emotional ^{was} being especially liable to weeping.

13, 1936 A month after coming into hospital, the patient ^{was} in her first outburst. She threw a plate across the room ^{was} she says, she ^{felt} felt angry. She was angry because she couldn't ^{was} and things. She feels more in contact with her surroundings ^{was} is unable to express her thoughts with regard to her illness. ^{was} Next three months she had periods when she lay in a stuporose ^{was} refusing to answer questions, periods when she was more ^{was} active on general topics, and periods when she had strong ^{was} of resentment and **sometimes** outbursts of violence - out of the ^{was} when she would throw things about or march up and down the ^{was} . She was afterwards unable to explain these outbursts, and ^{was} appear to have had hallucinosis. After four months in ^{was} she was well for a fortnight. Her behaviour was perfectly ^{was} and she was an agreeable patient in every way. She spoke ^{was} ly with her friends and made contacts with other patients. ^{was} Period of good health lasted for a fortnight. In the evening ^{was} and of that time she was resentful with some of the patients ^{was} noisy. The next day she had her head in the blankets and ^{was} ing to herself. She said that she had been chloroformed the

Cassie AuldProgress (cont.)

before - a nurse poured it over her neck. It did not make unconscious but made her sleep late. (Another patient in the room had had an emergency appendectomy done).

She has been worried about things - love affairs. When she to Kingston (where she was cook in a school) she first went to "mission" to services on Sundays but was dissatisfied with this

When she left she was asked if it was because she preferred minister in the church to the mission pastor, and this she taking it to suggest that she was in love with the minister. she went to his church, however, she fell in love with him and convinced that her love was reciprocated. Nothing was said on side and they behaved quite normally in the presence of others, but there was a secret understanding. She refers to moments on which she was quite sure that there was such an understanding.

This was the state of affairs at the time of the late King's death. She was unable to attend the funeral (being near London) the headmaster in the school attended it. She thought, she quite convinced that the headmaster was of royal blood, the next the Duchess of York, and that she, the patient, was twin sister Princess Marina. She was making very definite plans (which she remembers) for what she would do when she would be Prince Edward's

When she came home she forgot all about the royal blood her mind was occupied with not having heard from the minister. thinks at present that the delusions of royalty were the result of constipation and late nights at the time of the funeral, but she

Progress (cont.)

believes that the minister is in love with her though she
ever heard from him and it is now a year since she saw him.
A family episode seems now like a dream. The masters at
school were to kidnap her with a sheet out of the window, and
a change of life was to begin then. This time marked a change
in symptoms. There has since been no tendency to stupor but
there have been periods of good health alternating with periods of
madness with flight of ideas, distractibility, bad outbursts of
violent anger, throwing about of dishes, openly undressing herself,
references to sexual intercourse, refusal of food, refusal of
company. Sometimes she would be very difficult to keep quiet and
talk day and night. An example of her conversation in one
more subdued of such periods is as follows:-

(See Over)

Patient: Oh, it's funny.

Doctor: What is funny?

Patient: That's where you were brought up - Oh yes, at the Royal High School - No - at Heriots, where the buses went to Prestonpans. Oh, my funny mouth (looking into the mirror). My mouth's a wee bit wrong. Oh, can you give me something that will make me sick. I wish I was in France at the moment. Well, Sister Bruce and Dr. Ross asked if I would go to Lourdes and then I said "Yes" and changed my mind. Well then my place is booked and I want to go and I am going when the time comes. You take the words out of my mouth. I've already told you there is a pilgrimage to Lourdes. You know you are not straight, Doctor, you have to be careful, you are in for trouble my lad. How much blood have I lost since I came in here? Repetition - parrot-like you. I want a wee, wee leaf of orange and I want a sweet because my throat is so dry and then she does the wrong thing. I have suspicions - I know she does not like me. She does not wave me in. She lifted up my hair and helped me to take my dinner.

Cadzow happens to be a relation of Mr. Fordyce. The only one I met was McMeechan's brother. Of course Dr. McInnes and Dr. McIntyre and Dr. Lund all in one happen to write with a funny pen nib. Dr. Ross of course asked the usual question. Of course Professor Henderson and some lawyers say she is to stay /

Patient (contd.). stay in bed. Of course the condition of the coroner called the bed of sin is horrible..... The police from Madeira..... Uncle Walter was there for his health. Of course this person had to stay in hospital. I understand now what Jubilee is about. Christ is crucified again. Christ is crucified in more ways than one, and will no one come to see me and take me out".

She refers to other patients' relatives as if she knew them and is therefore very distractible, but the content of her thought at present is taken up with the love affair with the minister, thoughts of a pilgrimage to Lourdes, with the fact that she is not being allowed home and with frank sexual references.

She was well from 17th. January until February 2. She was disordered in her behaviour for the next week and came marching up to the office in her nightgown on one occasion. After this week she was normal in her behaviour, the only unusual sign being a certain pressure of activity, but her conversation was rational and her attitude co-operative. She was able to visit friends in the city. This lasted from February 10 till March 5. On this date she showed evidence of excitement when she was in a shop and other patients who were there were glad to get her back to hospital. On the next day she had pressure of talk, flight of ideas to the point of being difficult to understand and she wept when she said that her relapse was due to her people not waiting /

waiting to see her on Saturday but just leaving a note. It is probable that her delusions with regard to the minister have been given up judging from her reference to the subject.

This was the last good spell of any length and she was certified on April 17. It should be said that in her intermediate moods when she was neither well nor so aggressive in her attitude and disordered in her behaviour as to be entirely unreasonable, the main theme of her remarks was her desire to get home.

A full report is given of a further case of a similar nature. This case is intermediate in respect of environmental influence and individual evolution of delusions. The prognosis is also intermediate. The patient has been able to continue her work for four years with a psychosis. At present she is successfully learning shorthand and typing having given up the idea of attempt to re-enter the teaching profession.

Miss Jean White

Aet 30

Admitted - September 4, 1936.

Discharged - October 24, 1936.

In Hospital - 7 weeks 2 days.

Personal History

The brother, who is a well-balanced individual, gives the following account.

He and his sister were brought up in a peculiar way. They were taught by their mother to believe that there was something special about them; that they were superior to their surroundings and that they should not engage in the ordinary life of other children, although nothing was supplied to take the place of these interests. He considers that his being good at games allowed him to have more contact with other children, and that it was an important feature of the patient's life that she remained separate, very quiet, and under her mother's influence retained the contemptuous attitude towards others. He and his sister were constantly quarrelling. She was reserved and always appeared timid and shy in company. She was proud, always expecting others to make advances to her and to give in to her. She was very anxious to be liked, but at the same time despised those who wanted to like her and the brother considers that this whole illness is/

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is the outcome of an exaggerated opinion of herself which she is unable to get the world to acknowledge. He thinks that the patient has been harmed by not being a success with men, and that she must have been offended in view of the fact that she was not liked in the same way as other girls whom she considered inferior. The patient relates that she never felt very strong or had much energy in her young. She worked hard at school, taking six highers, besides certificates in music and drawing. At the university she remained for the most part living her own life and took little part in social activities. This has also been the case during her life as a teacher. Teaching she dislikes, and in particular she dislikes the necessity for keeping strict discipline. She objects to the standard of military discipline demanded, considers that laziness on the part of children is largely due to physical causes, and thinks that a child who is naturally alert will always be willing to work.

She tells how she allowed her affections to run away with her at the University, when she experienced an infatuation for a man to whom she had never spoken. This lasted for some months. She missed him one day from classes and learned that he had left Edinburgh. She had a feeling as if she had had an actual blow on the epigastrium. She continued her work, but some months later she became weak, felt her/

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her bones and her whole body weak, and was attended by doctors on this account. Although there was a disparity in time, she relates this illness directly to the shock she had received. One day she was out with a girl friend who made her laugh, when the patient was sad and not wishing to laugh, and this terminated her illness. After that she was brighter and in a better mood than she had been for years. She felt fit for anything and was much better than she had been before the shock. She wished to return to the University and to make a better success of it than she had done. This feeling of personal satisfaction in her life remained with her from the age of 23 till the age of 26 when the present illness began.

Previous Physical Health

At the age of 13 the patient had an excision of glands of the neck. In addition to the usual children's diseases she was unduly troubled by nasal catarrh. From the age of 15 to the age of 23 her appearance was marred by acne of the face which worried her a good deal.

Present Illness

The brother believes that the illness began suddenly four years ago when the patient was 26, about two months after she had been introduced to spiritualist beliefs by her father's sisters. She returned home after a railway journey in a state of great agitation. She was put to bed and wrote what/

what she and her parents regarded as automatic writing. Both her father and her mother were convinced of its true spiritual origin. She wrote letters, some of which were sent to outside people. They were unpleasant letters, judging from what the brother was told by the recipient of one of them. They seemed to be full of spiteful remarks. The brother was referred to in some of the automatic writing and he recognised the content as being patient's own opinion of himself, distorted to some extent and with the more critical points emphasised. He has never been anything but sceptical of the spiritual basis of her thoughts. After four and a half months at home, the patient resumed her work as a teacher and remained working for three years. She stopped automatic writing but continued reading psychic books and going to psychic meetings. She was not, so far as he knows, considered to be a medium by fellow spiritualists, nor was she given a place of importance at their meetings. She and her mother were very much together and had always the same opinion about everything. There was one woman to whom they took particular objection. On the whole the mother was more virulent than the patient in her opinions of others and took strong dislikes to relatively inoffensive neighbours. The patient, during the time that she was continuing at work, would often

be/

be found smiling or talking to herself. At times she would be worked up into a frenzy when she slapped her own face. She appeared to be doing her work satisfactorily, the brother knowing of only two untoward incidents, both having regard to punishing a child too severely. She would give expression to the thoughts that everyone was against her, and that she was never being given a chance. She would be happy and depressed by turn, at one moment secretly smiling to herself in a very pleased way, and at another time crying, shouting and slapping herself. There were no variations in mood over any length of time.

The patient relates that four years before admission to hospital she was introduced to spiritualism by her aunts. Two months later she went in for automatic writing. For a week at that time she considered that she was a medium, and during that time she heard voices. She one day travelled on a train from Perth and during the journey she had a sudden feeling as of a blow on the head. She felt as if there had been an explosion inside her head. She thought at this time that she had come under the control of a very wicked spirit. She relates that she was in bed for four and a half months, was very ill, was being "put through hell", and heard voices continually speaking to her. The voices got hold of some of the facts of her life, and they blamed/

blamed her for things done and for things not done. Later she sometimes visited people under the instructions of the voices. Since that time other people have, for the most part, been unfriendly to her, but there have been no particular enemies. She returned to her work after four and a half months after a medical examination, and continued working for three years, till nine months before coming into hospital. During that time she was continually hearing voices and she believed in them. She thinks she was able to do her work satisfactorily, but found her relations with people interfered with by the voices and gradually lost all her friends. She would write letters to them or visit them and make unfriendly remarks, both in her letters and at her visits. Resigning from her work, nine months before coming into hospital, was preceded by some months when she felt much better in herself. This feeling of well-being was caused, she considers, by getting rid of the evil spirits. At times she had the sensation of being squeezed with great pressure by some outside power, this power, she thought, being the evil spirit. At these times she had a desire to hit herself, in order to get the evil spirit out of her, and she frequently indulged in self-punishment. She smacked her face, and thrashed her legs with a school/

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school strap until she raised weals on her skin. She refers to an incident, as if important, at the time of her self-punishments, when she tore up documents with great energy. The only one of these documents she remembers, however, was a letter from a soldier, written during the War, in thanks for socks she had knitted which had been handed out to him.

The content of the voices during the four years of her illness mainly consisted of conversations of a low type, and she has had to refrain from listening to such conversations. They have been taken up with the idea of sex. The voices tried to relate everything to sex. They were real, coming from the outside, and there were various voices of different types, both male and female. They reminded her of what she had heard of some French books written with double meanings, and, as a result of what the voices told her, she could never see any word without reading a sexual meaning into it. On several occasions she visited a psychic healer "who has power from his hand". She felt that he could influence her body and that his power arose from the fact that he led a very pure life.

Present Illness - Since giving up work.

After carrying on for three years, and feeling more satisfied with herself for the latter few months of this time, she felt her objection to teaching increase/

increase, and quite suddenly resigned from her post unconditionally, without medical advice and without asking for sick leave. She gave as a reason that she found the work uncongenial. Her brother relates that it was during one of her bursts of energy that she threw up her job, and that she was very sure that she was doing the right thing. She had an intuition that the thing for her to do was domestic service and this she immediately entered into with great energy. Her brother is of the opinion that she was sick of herself, considered herself an outcast, and felt she was fit only for manual work. The domestic service did not last long, and in five months she applied for reinstatement into teaching, her doctor certifying that she was fit for work. She was not passed at first by the Authority's doctor, but was later considered to be fit for work in the country.

She was at home all day during the few months before coming into hospital, and during that time her behaviour was most erratic. Sometimes she got up very early in the morning and helped a great deal with the housework. At other times she was still in bed when her brother went out to his work. She ate constantly and excessively. She went occasionally to picture-houses and attended psychic meetings. She read a good deal but her brother doubts whether she understood what she read. She visited her aunts who use automatic writing. Her brother would never know/

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know what she was likely to be doing at any particular time. "Variability", he said, "was the only constant in her behaviour." She usually went to bed early to listen to her voices, for he would be irritated if she sat and listened to them when he was about.

Patient's Mother's Illness

The patient was introduced to spiritualism in the first instance through her father's sisters. The father and mother were convinced of the truth of the automatic writing, the brother remaining alone in his sceptical beliefs. The father appears to have been a man of rather passive temperament and of rather intellectual interests. The mother was regarded as a woman of strong character and dominating influence. The father died a year after the beginning of the patient's illness. The mother continued to believe in spiritualism. About three years after it was introduced by the patient, and about a year before the patient came into hospital, she was noticed by her son to become involved in the same way as the patient, her beliefs becoming more unusual and morbid, far beyond the usual tenets of the spiritualist faith. This occurred after her husband's death. She has always been able to do her work satisfactorily, and her conduct in the house has not been conspicuously abnormal in any way. She was interviewed and was found to have more/

more abundant delusional thought content, and a more obvious hallucinosis than the patient, with less insight into her condition. She believed that the patient was a medium who had been under the influence of an evil force, and she believed that she had been called in by good forces to rectify the balance and that her function was to create healing power. Her delusions, however, appear to be variable and confused. The scientists she believed to be setting the medical profession wrong by interfering with the constellations and the rays of the sun, and she had to guide the profession back to the influence of the good spirits of the dead. She was constantly hallucinated and when asked to repeat the words of the voices she heard she said that the doctor's father and grand-father would in a certain way and at a certain time be his direction. Two letters received when her daughter was in hospital read as follows:-

"Psychic interference in my home is the reason for my daughter's application for admission to your hospital. She is not mental in any way but interfered with by mental specialists and nurses who flit about in the invisible. They use rays. If I interview these people, matters will be serious."

And the other letter:-

"I am directed to ask you to allow my daughter home/

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home any time before Saturday. I shall call on Wednesday afternoon (visiting hours). I understand the case of my daughter has been to lead the medical profession to new healing powers. If I am opposing force has done otherwise I am sorry".

During an interview she suddenly introduced her delusions by the question: "Do you know the invisible man?" She then told how certain people were able to withdraw into the invisible and to have access to people's company, unknown to them. It was such people who entered her home and had a bad influence on her daughter's health. She said that some ministers of religion had this power and spoke of one in particular. They invaded the hospital and had power of sexual interference with people. If such a thing happened to her daughter when in hospital the place would get a bad name. The mother was, however, capable of carrying on a conversation of some length without introducing such material. She was quite without insight into its delusional nature. When the reciprocal influence between herself and her daughter was touched on she said: "Oh no, we do not influence each other at all. It's all psychic. Are you psychic?"

In Hospital

In hospital the patient gave the impression of taking quite a keen interest in all that was going on. Her behaviour was marked by purposeful activity/

activity and exhibited a good deal of energy, amounting to pressure of activity. There was a similar mild degree of pressure of talk. There was no flight of ideas, and the patient was not distractible, but rather tended to persevere on the one theme. The mood was one of pleasure for the most part and she appeared to have satisfaction in gaining a better knowledge of her illness.

Her leaving hospital was associated with an attitude of persistent self-assertion, and her feeling of superiority to others was then especially in evidence. Her conversation was carried on in a soft tone of voice and there was an appearance of passiveness and of modesty. There was no lack of feeling both with regard to her own affairs and her interest in other people, although her relations with others were very restricted. She was friendly at first with one or two of the patients, but when they left hospital she made no further friends. She derived obvious pleasure from living in the same room with others and from conversing with the patients she was friendly with. She believed that her life during the past four years had been a great mistake, beginning with the introduction to spiritualism and with automatic writing. She believed that the voices were truly external voices but that they were all alike dangerous, and that she would be best to have nothing to do with them but to/

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to have her attention taken up with the same kind of things that occupy other people's minds. Her voices would not allow her to be herself and kept her from acting freely. They wished her to be under the charge of a spirit, which she thinks is not right. All that she wanted was to have her mind clear and to be able to act as she wanted. "Otherwise", she said, "I am not an upright being". Although the voices had been for the most part of a low type, occupied with sexual matters, she believed that there were also "high spirits" which would want people to lead normal lives. If she were dead, for example, she would not want people to go into dark rooms and to listen to spirits, but would prefer them to lead healthy lives outside. She declared herself as being disappointed in her mother's carrying on with spiritualist beliefs, and said that she had tried to get her back to other views.

In hospital, the patient continued to hear voices. Their general import was to prevent her from carrying out anything that she might be doing, her daily tasks being constantly interfered with by the hallucinosis. She was not, for example, to make her bed in that particular way. She became able, however, to go out quite freely, and she considered it a step forward when she could read with attention and without feeling that her mind was in/

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in outside control. She complained of strange sensations referable to the lower abdomen and the genital region. She described the feeling as being as if an instrument touched her. Again they were described as feeling of a sexual nature, as if her body were being interfered with. She considered, however, that her body was not under control to the extent that it had been; that whatever had been in her brain had left her, and that her body was in her own control again. She reverts to the period when she thrashed herself in order to effect the same thing - to gain control over her body which had been taken charge of by an evil spirit. The voices at that time had been insistent that she should take a stricter view of religious matters, particularly with regard to the bringing up of children, and this she describes as a cruel view.

After being in hospital for seven weeks, the patient left to go home, against advice and against the wishes of her brother, whom she disregarded. She had a feeling of compunction with regard to her mother's illness, having introduced her to these forms of belief in the first instance, and she was going home in order to persuade her mother to give up these beliefs. She was very stubborn and her attitude to her brother was most unreasonable. She attempted to prevent his being interviewed separately from herself and/

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and effectively prevented her mother being interviewed except with her. It was not clear whether she was acting under the influence of hallucinations.

Physical Examination

The patient was small in stature and was thought to conform to a boyish type of build. She had had cervical glands removed in childhood. There was no evidence of disease.

So far attention has been paid to the occurrence of belief in the psychosis and its relation to pre-psychotic and to normal belief. It is suggested that where morbid beliefs have been held in association with others then their relation to normal belief is easier to make clear and the development of such belief into frank delusion is not of such grave import as might be thought at first sight.

The next cases to be reported deal with an extension of this principle into the realms of the entire affective response. The cases are of patients who are natives of the Islands of Orkney, coming for the most part from country districts. The symptomatology of their psychoses taken in relation to the course, indicates that among people coming from such an environment an apparently schizophrenic type of psychosis has not the ominous prognostic significance that such a response would indicate occurring, say, in a townsman from the south.

Reports of cases of Orcadian patients indicating an extension to the whole field of affective response of the principles already elaborated in relation to belief.

Short reports are given of six cases of patients who recovered after illnesses in which schizophrenic features were marked, in some cases dominating the clinical picture. All patients were under 30. They conformed to Strecker's theory of the better recoverability in cases predisposed by upbringing and environmental circumstances to a schizophrenic type of illness, all being natives of the islands of Orkney.

The illness of these patients runs a fairly definite course. Beginning with an insidious depression, this depression becomes more acute and ideas of reference and delusions of persecution become prominent. This phase is followed by a period of excitement. In the case of the two women and in one of the other cases the excitement was accompanied by elation. In all but one case it was accompanied by violence or attempted violence. Hallucinoses was sometimes present. Attempts at suicide were also made during the excited phase. This phase was followed by a period of apathy with later recovery. In some of the cases the initial depression /

depression approached a stupor reaction and the excitement simulated the hypomanic phase commonly seen after such reactions.

The case of a seventh case where recovery has been inadequate is added.

The patient was ambitious, hard-working and was always on the look out for making money. He got on better than his father as a fisherman and took him and his brothers into partnership with him in three boats.

He was his mother's favourite and was very much attached to her.

He did not spend much time in running after girls. Several times, however, he thought of getting married and then decided that he was better off as he was.

He was independent of his own people and had the reputation of not getting on well with them and it was said that he pulled better with strangers than with his own people.

His mother died when he was 24. He thought a great deal about her death. He remembered he had bought her some sweets and began to wonder whether these could have done her any harm.

Shortly after that he had influenza and then he was never free from aches and pains. He had pains in the stomach and then pains in the back and in the chest, and headaches. He brooded over the meaning of these pains and began to lose sleep.

Two and a half years after his mother's death he took a trip to Edinburgh and was examined at the Infirmary. He was referred from there to Jordanburn where /

where he was seen as an out-patient.

Shortly after going home he went away for a week on a trawler to help him to get rid of the pre-occupation with illness. This did him little good.

When he returned to settle down at home he wanted to sell his boats. His father and brothers were very much against selling up and there were frequent family quarrels. The patient admits that he always had a bit of a temper and this temper became very evident in the family quarrels. He also took drink which was inclined to make him more aggressive.

He became aggressive towards his father. He thought that his father was bossing too much in his boats.

He says that all he wanted to do was to sell up and go away and be on his own and his people prevented him from doing this.

He refused to go out with his father and brother in the boat for fear they would drown him. Once when he was lying in bed he saw ships move out over the water in front of him. He knew they were not there.

He still had aches and pains and believed that his spine was completely useless. He said that he was suffering from a disease that no doctor could discover.

When he was excitable he would either be angry or weep. /

weep. He struck out at the housekeeper. He ordered all the family out of the house and chased the housekeeper round the house with a knife. He broke windows and furniture and went round the house at night kicking the doors.

When he came to hospital he was not confused. He knew that he had been bad tempered and put this down to his having bad health. He considers that his father got him certified because he wanted to sell the boats. In hospital he showed no aggressiveness. At first he complained of his health but not later. He worked hard outside. He showed a certain indifference to his surroundings. He was in hospital for nearly three months.

He is described as a bright talkative boy but he was inclined to day dream and he did not mix much with other young men.

He had a febrile illness which was regarded as precipitating a depression at the age of 19. He became quiet, refused to talk, and appeared to lose interest in everything. He became suspicious of the neighbours and said that they molested him. He said that people followed him in the street and annoyed him. Character and outlook changed within the course of four months. He then threatened violence to his father and was sent to hospital.

After a week in hospital he began to lose the attitude of suspicion. He said that he attacked his father because he wanted to be left alone and his father was disturbing him. He still believed while in hospital that the neighbours talked about him and annoyed him.

He completely recovered in a few weeks and left hospital within three months.

After returning home he remained well for five years. After that he was out of work and the lack of work seemed to depress him. During this unemployment he began to read books on hypnotism and strengthening of the will. He also studied wireless. He read a great /

great deal and pondered questions of the mind and the universe, the books he read having to do with the religious and the occult. He studied Jogi worship. He began to entertain the idea that he was being influenced by hypnotism. He knew this to be an unusual idea and was very sensitive about it. His mother says that during these two years he had moody turns. As time went on these attacks became more frequent and he became more violent in them till he had to be removed. He turned his mother and sister out of the house, stuck a knife into the door and threatened to do for a neighbour.

He was in hospital $3\frac{1}{2}$ months. He gave the impression of being rather suspicious and very reserved and sensitive but in time became more communicative. Latterly his main pre-occupation was to go home.

She is described by her mother as being of a quiet and peaceful nature.

Her brother was mentally ill at home for two years before his being sent to hospital for the second time. The worry and strain during these two years on her mother and herself was considerable.

The menstrual periods were irregular, sometimes not for 4 or 5 months. She was very worried and excited when her brother was taken away but recovered her composure and was at work on the farm for about four or five weeks after he left. She then became weak and fevered and took to bed. She would not let the doctor examine her. She had bleeding at the nose.

She then became noisy and excitable, shouted and sang hymns, was hilarious and unduly talkative, and abused every one with much bad language. She was removed to the County Home in Kirkwall and there she tore down a gas bracket from the wall, and had to be tied hand and foot to prevent her from destroying property.

On admission to hospital patient was confused, thinking she was in hospital in Kirkwall. She was mildly elated and hyperkinetic.

She later gave as the cause of her illness that she had been worrying about her brother, thinking that people /

people were making a fool of him, that she had been working too hard, and that she had had influenza.

After the influenza she felt very tired and exhausted and only wanted to rest, but at the same time she felt elated and kept talking. When she was admitted to W.H. she tried to keep talking so that she would not think where she was. All the time however she was only very tired and wanted to rest.

The patient has been a domestic servant and about six weeks before admission she became strange and irritable. She took a great dislike to her parents and then became excited and noisy.

She told her doctor that a neighbour had poisoned her by inserting lead drops and verdigris into her fingers.

On account of her excitement she had to be watched closely for five weeks before she was certified. She hurled the pillows from her bed saying they were chamber pots and that she was hurling them at a neighbour. Her conversation was at times incoherent. She meddled with everything within her reach. There were periods of gloominess alternating with the periods of excitement. When she came to hospital she was exceedingly excited and noisy, talking incessantly, showing very marked flight of ideas, almost incoherence, and a great distractibility of attention. She was put to bed and at once proceeded to tear her sheets, blankets, and clothes to ribbons. She had bruises all over the chest, arms, and legs. The excitement was maintained for a month after admission. She refused to keep any nightdress or strong suit on but occasionally wore a black coat. As a rule she danced about her room naked. She was very /

very elated and pleased with herself and at times rather witty in her remarks. After over a month the excitement was rather less and she remained irritable, and emotional at times, with distractibility of attention and a habit of making faces at people. Four months after admission she required only a few days in bed on occasions on account of attacks of excitement. She was discharged in a year after being in good mental health for three months.

The patient suffered from nocturnal enuresis up till the age of 11. He is aware of having been subject to excited turns which recently have become more severe. For some years he worked as a farm hand, but tiring of this, left it to go to his home and there he scarcely ever went out. 'The sounds in the street' affected him. Recently, when staying at home, his mild depression gave way to an attack of excitement. He realised that he was excited and knew that the doctors were at his house to examine him, but could not control himself. At this time, he heard voices of people speaking to him. The voices were accusatory and spoke of him as worthless and lazy. The doctors called to examine him and found that he was restless and excited. He was talking incessantly and incoherently, using foul language, whistling, and laughing without cause, and singing what he wished to say. He said that he had been through the Great War and had been wounded at the Dardanelles (although he would have been only eight years of age at the time). He had threatened suicide by drinking half a bottle of medicine. He was violent and threatened to strike. When he was admitted to hospital he was correctly oriented with regard to time and place but was confused as to the /

the people around him, recognising, in the nurses, people he had seen at home. He would smile in a foolish inappropriate way but was not excited, and in the course of a fortnight the confusion was found to be disappearing, while he was discharged recovered in four months' time. At that time he was rather shy and good natured and neither depressed nor elated.

The patient's mother died when he was a few weeks old and his father went to America shortly afterwards returning when the patient was seventeen. He was brought up by an old woman and after schooling went on the land at the age of fourteen. The present illness began at the age of twenty-three. He was a good steady worker, when, a year before his admission, he became lazy and drifted from one job to another. He became quarrelsome and was very ready to pick a quarrel and to be provocative, and became known as aggressive and a ready fighter. He attacked his relatives, his aunt and sister, and they lived in terror of him. On one occasion he hurt them and they had to call for help. His doctor found that he believed that every one was against him, especially his friends, and that his threatening to attack many of his neighbours was because he thought they were his enemies. He talked excitedly to him about secret societies and widespread secret conspiracies against himself. On one occasion he took a group of people whom he saw to be German spies. He was frightened and crawled along a ditch. During the present illness he took to drinking and prowled about the country at night, drinking and getting into trouble in all sorts of ways.

On /

On admission an idea dominated his mind that his people had sent him here because of a spite they had against him. He was exalted inasmuch as he believed that he was a very great man and wielded a good deal of power over his fellows.

As regards his conduct he was in an extremely agitated and excited state. He was noisy in his behaviour, shouting and swearing at the attendants and at the other patients who came near him and who attempted to prevent him breaking dishes and furniture. He was impulsive and there was general overactivity. His volubility was a marked feature. He was resistive and quarrelsome, and it was impossible to keep him in bed both during the night and during the day without large doses of sedative.

He did not improve much for over three months. He then began to be more co-operative and more composed, and after a year in hospital began to express the desire to go home.

He was discharged two years after admission. He had been in good mental and physical health for six months.

Thomas Smith aet. 22

The patient's mother died when he was three and his father married again three years later. He was a shy youth and three stepsisters by a third marriage teased him about being timid and shy. As a youth he had periods of sadness and extreme depression. He went to college ~~in~~ at 18 and when he was in his fourth and final year his father committed suicide. Having had periods of depression for five years previously when he had threatened to take his life. When he was at home after this event he was noticed to become restless and excited, talking incessantly, behaving noisily and conducting himself ~~foolishly~~ foolishly. It is mentioned that he had ideas of reference. When he came to hospital he said that he had been sad on account of his father's death and on account of the fact that he had been told he couldn't afford to return to college. He showed great pressure of activity, rapidity of talk, flight of ideas, and distractibility. He was excited, constantly jumping out of bed and requiring paraldehyde daily. He was elated. He was not confused. After a week or two in hospital he became noisy and resistive, was confused, disoriented and very excited. He struck himself with his fists. He attempted self-injury by throwing himself violently out of bed. He attacked an attendant. This condition lasted for six months when from a state of extreme excitement he passed into a state of apathy and indifference bordering on stupor. He was mute, and negativistic, but seemed to know what was going on about him. Six weeks later he recovered from this state and became interested and co-operative. He began to study and six months later he passed his final examination his recovery being considered complete.

There is no family history of mental illness. He was normal until five months before admission to hospital when he became dull and depressed, which was attributed by his mother to an unsuccessful love affair. ~~Shortly after this~~ his father was taken to a distant hospital and died before the patient reached him, but he appeared to recover from this grief. The depression beginning a few months before his admission ~~was~~ increased. He sat about brooding without noticing what was going on about him. He became sleepless and the assistance of neighbours was brought in to prevent his committing suicide. He was restrained in his own house to prevent his drowning himself in the sea. He improved from this condition, relapsed into the depressed and ~~an~~ apathetic state, until shortly before he was sent to hospital when he became excited. He threatened violence to his mother and to those helping him with his croft. He talked more rationally to strangers but in his own house he spoke of 'sounds from above' and of 'thunderbolts striking him'. It is noted also by his doctor that he heard voices all round him, that his temper was uncontrollable and that he struck his mother and kicked the islanders who came to watch him. He had to be restrained ~~xxx~~ at home by being tied in a tarpaulin, and a cart was taken to his croft for him to be tied in to bring him to the pier, but when he saw this he walked quietly with them. In hospital he was extremely reticent and would fight the attendants if they annoyed him. He said that he had seen 3 'balls of fire ^{from heaven}' and that he had heard voices when he had 'gone too far in his thoughts. He appeared to have some insight into his illness and formed a conception of it in these words - 'This is a thing higher than the ordinary level of life. There is a high depression of the ~~the~~ body and a low one; one kept you down and the other carried you higher', and asked which ~~feeling~~ he was in at the moment, he said, 'I am in the lower feeling, a heavy feeling in all my limbs.'

He sometimes got excited at night for no apparent reason. He did not admit to any ideas of reference but was very sensitive and rarely would take part in any conversation, not speaking, for the most part unless he were annoyed. For example when it was suggested that he did not get on well with other people at home he became very angry and said he was damned sure he got on fine with everybody.

He became lighter in mood after a month or two in hospital and was rather more communicative but remains after two years in a very indifferent and apathetic state without apparent intellectual deterioration. ~~His doctor visited him and says~~ It was thought that this appearance of apathy might be constitutional with him particularly as he came from a very remote island, but his doctor visited him and found him much different from his former nature, ~~which~~ which was marked by intelligence and industry.

Influence of E

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Influence of Personal
Beliefs on the Psychosis

ALL These cases have much in common with the cases of Strecker's from which he makes the deduction that a more favourable prognosis can be looked for where the psychosis develops in an environment in which abnormal beliefs are current when the delusions appear fairly obviously as an outgrowth of habits of personal belief. It is generally regarded that a slowly developing psychosis, with a long prodromal period of social maladaptation, is an illness of bad prognosis. In such a case it is impossible to distinguish between features of the personality and symptoms of the psychosis. Strecker, however, is able to make a much clearer distinction between the outlook of his patients in health and in illness and proceeds as follows: "In the majority of the cases we feel that an alignment between the symptomatic material in its hard outlines and sometimes in its details and the main elements of the prepsychotic conditions and experiences has been established, and in the light of such coordination much of the psychotic reaction becomes understandable and correspondingly admits of more favourable prognostic judgment." Looking back over the progress of a number of schizophrenics who have recovered, he considers that ^{if} the seemingly malignant features could be traced to the personality rather than the psychosis then a less gloomy prognosis would have

have/

been given. He refers to the case of a woman who heard the voice of God, and believes that the fact that she was a spiritualist indicated that the hallucinosis was more in the nature of an outgrowth of personal belief, than significant of a disintegrating process. He distinguishes between features that appear in the psychosis as foreign elements introduced from eccentricities in the personality and features inherent in the psychosis moulding its character. The eccentricities in the psychosis he believes to have even less unfavourable prognostic significance when they are evolved not only from personal peculiarities of thought, but when these habits of thought are found to be held in common in a community, family, or race. He has in mind cases of recoverable schizophrenia occurring among Jews, cases of catatonia occurring among isolated farming communities of German extraction, and cases of a paranoid kind, occurring in groups of people, accustomed to a minority religious or political outlook. Theodore Hoch lays emphasis on the same points in discussing his cases: "So often our impression that a case will not do well is founded upon traits which superficially appear to belong to the dementia praecox group but searching analysis later reveals them to be but atypical reactions, depending on the bringing up, the social level, education, environmental opportunities, the inherited make-up, beliefs,

beliefs, and superstitions." He adds later that the personal history may strongly suggest dementia praecox, the delusional ideas and reactions may also be suggestive of a deteriorating type of disorder, and yet we may be dealing with a pretty pure type of acute psychosis, such as a simple depression, into which the slightly odd personality has obtruded itself and has been prominent enough to confuse the picture.

These are illustrations of the unfortunate tendency to suggest in view of a recovery that the diagnosis might have been different if things obvious on looking back into the illness had been more fully realised at the time. The hankering after a change of diagnosis in view of a recovery is a weakness of Strecker's contribution and if encouraged would amount to a reflection on the barest use of diagnostic terms. Strecker's contention is valid that when patients come from a schizoid environment this has to be taken into consideration in assessing the prognosis.

He goes on to discuss the process underlying the more favourable course in these cases where the beliefs were morbid before the onset of the psychosis. He lays emphasis on 'threads connecting the content with the previous life of the patient', and if this connection can be clearly made out the psychosis becomes 'susceptible to analysis', or 'understandable'. That a better prognosis can be considered when the psychosis/

psychosis is 'understandable' is a familiar enough conception. The Manic-depressive psychosis is regarded as easier to understand than the schizophrenic and the better prognosis is regarded as having some relation thereto.

The cases that we have described may be 'susceptible to analysis', 'in themselves and in their psychoses', and to some extent might be described as 'understandable'. This would imply that the more fundamental emotional responses, underlying their conduct and beliefs could be related in some way to the natural feeling of ordinary people. It would in fact mean that their behaviour was governed by fear, anger, elation, and the rest in such a way as to produce a pattern of conduct with which we would feel ourselves familiar. To feel that we have some familiarity with a process, however, on the basis of subjective experience, is rather different from saying that the process is 'understandable' if we mean by understandable that it can be understood. The fact that everyone gets a cold in the head does not help anyone to understand it. The paranoid process may prove to be as easy to understand as the depressive, in its pathology, although its frank exhibition is less familiar to us, and the associated psychoses more malignant. Instead of the word 'understandable' it might be better to use some such term as 'familiar on the basis of subjective experience'. An abnormal process may be to some extent familiar/

familiar as an extension of a normal process, but this is different from understanding, for the 'normal' process is not understood. Health is appreciated from a study of pathology, but pathology cannot be described in terms of health. 'The symptoms of disease have thrown much light on the dark places of human physiology. So with mental diseases and normal psychology. Mild depressions in the normal person though familiar, cannot be understood, apart from an understanding of the manic-depressive psychosis. They are however, of better prognosis. The more a psychotic reaction can be appreciated as a response of the kind we are familiar with in the non-psychotic, the better the prognosis. This is the same as to say that the less ill the patient is the more likely is he to recover, which is, after all, the basis of all rationalisations of prognostic verdicts, so long as pathology remains obscure.

The terms 'understandable' and 'susceptible to analysis' have the further disadvantage that cases vary so much in this respect with the extent to which they are studied and the imagination of the examiner. To substitute the conception of the extent to which the reaction can be appreciated as the type of response we are familiar with in the non-psychotic evades this difficulty to a certain small extent.

This generally approved conception, in whatever terms it is put, is further expounded by Meyer when he/

he indicates that the essential feature of the schizophrenic type of illness lies in the greater degree of distortion of the personality in association with the psychosis. Taking Strecker's views along with this conception and applying them to such cases as we have been considering it could be said that for a patient who was deeply involved in a quack religion it might be no distortion of her personality if she were to speak with voices, and it might be an understandable response on the part of our patient when he dramatised the crucifixion, being a masochistic young man carried off his feet by a quack psychologist who talked a lot about union with the divine. Absence of distortion would seem to mean that we can feel ourselves familiar with the process, that in terms of ordinary language, the psychosis is a natural response. A distortion, on the other hand would imply a change that could not be predicted in terms of an understandable response, having regard to the features of the personality. It has already been pointed out that personality in these cases of patients who entertain unusual beliefs, is to some extent a morbid one. Before the onset of the psychosis their outlook is to some extent distorted. Following out the line of reasoning, it would appear that, where the personality and the psychosis can be separated with any feeling of confidence, then an understandable response, occurring in a distorted type of personality may/

may be of good prognosis. A response, or development, which is more difficult to understand, which involves some distortion of the personality, even if that personality was not previously consciously unstable, would be of worse prognosis. It may be that such theories can be found to apply to numbers of cases, and to some extent they would seem to have some meaning for the ones we have described. Nevertheless they appear to be contradictory to the accepted view that a better prognosis can be expected in psychoses occurring in better endowed personalities. The theories are however in line with Mapother's observation: "A priori one might expect that the resilience of a person thoroughly normal until broken by exceptional disaster, would assert itself and therefore that recovery would be exceptionally frequent in such cases. I have noted a statement to the contrary in Maudsley's 'Pathology of Mind', and there is of course an old saying about the effect of storms on oaks and reeds. I believe the chances of the weakling upset by trifles are the better." In the same context Mapother says that the graver psychoses precipitated by really severe mental stress are apt to be syntonetic rather than schizoid. It may be that schizophrenia only rarely occurs in a well integrated personality so that there is less contradiction than might appear. Henderson has reported two cases of schizophrenia, occurring in well integrated personalities, without recovery, the psychoses being precipitated by war experiences.

ENVIRONMENTAL INFLUENCES, PRE-PSYCHOTIC
TENDENCIES AND DISTORTION OF THE
PERSONALITY IN RELATION TO PROGNOSIS.

In considering the prognosis in our cases in the light of this discussion, we will bear in mind these conceptions:

(1) That where the prepsychotic tendencies are morbid, the psychosis may not portend malignancy to the same extent, as where the psychotic beliefs arise in a person who has not been subjected to morbid environmental influences and where pre-psychotic beliefs were sane and healthy. This conception is illustrated by the fable of the Oak and the Reed.

(2) The usually held belief that the prognosis is better in proportion as the pre-psychotic adaptation is good.

(3) The conception of the extent to which the pre-psychotic belief can be considered as a type of response that we are familiar with in the non-psychotic, or the extent to which it reveals gross distortion of outlook; that is, the gravity of the mental aberration.

In all our cases the patients have been subjected to purely invalid environmental influences. In two instances these influences no longer operate and in these cases it would appear that the outlook is good, in proportion to the extent to which the psychosis has depended on external support.

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It is clear that the fact that the observed onset of the psychosis reveals a gross distortion in outlook, is of more grave prognosis, than the fact that the psychosis arises in an inadequate personality. This is also the logical following out of Strecker's views on the better prognosis to be looked for, where the psychosis constitutes a more obvious development from pre-psychotic thought, especially where the pre-psychotic beliefs are shared with others.

When the conclusion is so divergent from the usual belief that good prognosis is closely related to good pre-psychosis, it is tempting to speculate as to possible explanation.

The cases can be put in order of affective severity as follows:-

- (1) The most severe - the patient with apparently adequate adaptation up to the age of 28.
- (2) The patient who espoused the Spiritualist faith; involved her mother, and supported by the mother, continues in a delusional state.
- (3) The patient, with facial haemiplegia, who had manic and stupor reactions.
- (4) The patient who went to a psychologist for treatment and was assisted by him into a psychosis.
- (5) The patient, who was involved with some others in a religious sect.

The first patient had the most adequate character
*and/

and the last two had less adequate adaptations, and yet the psychosis from which they suffered, showed a greater degree of reversibility. It seems reasonable that where the psychosis is partly the result of environmental suggestion, recovery may also come about through environmental suggestion.

On the other hand, where the onset of the psychosis is characterised by the sudden appearance of unusual beliefs, held in a very individualistic way, there may be evidence of a very deep, inner necessity of expression. The common beliefs being insufficient to satisfy this necessity, insane beliefs are evolved, which are destined to transform the whole character by a gross distortion.

It is difficult, however, to explain away the anomalous position of holding the belief that a less favourable prognosis may be given, where the pre-psychotic history is better. Perhaps if an easy suggestibility and morbid thinking in the environment could be looked upon as precipitating situations, then it might be said that the cases with the clearer precipitating situation had the better prognosis. But the questions of suddenness of onset and apparent adequacy of previous character would remain ambiguous in the assessing of the prognosis.

The Relation of the Foregoing to Insight.

The conclusion that a distortion of outlook is more important in prognostic gravity, than an inadequate personality, can be amplified. In the distortion of outlook, there is the suggestion of the two relationships; the relationship to the pre-psychotic thinking, and the relationship of that thinking to the thinking of other people. When such relationships can be clearly made out, a better prognosis can be suggested. The easier it is for the examiner to make out other relationships, the easier it will be for the patient to make them out also. The extent to which the patient can relate his delusions to his pre-psychotic beliefs and then to the thinking of others, is a measure of his insight.

The type of cases described have been such, that interest has centred around the questions of belief in the pre-psychotic history, and delusion in the psychosis. If the degree of insight has some relation to the importance of pre-psychotic beliefs and their relation to the beliefs of others, and if it has an inverse relation to the degree of distortion of the personality, it may be that the common measure by which the two factors can be assessed. The former conclusions might then be expressed in simpler terms; -

X That/

That so far as the present cases are concerned, and so far as the questions of the beliefs and delusions are important, insight in the psychosis may be equal in importance to the sanity of former beliefs, in the assessment of the prognosis.

It has already been pointed out that just as these patients, who derive their intellectual ideas from abnormal sources, have to be differentiated from others in their psychoses; so those who approach more primitive types in their emotional response, require to be differentiated from others in their psychoses.

S U M M A R Y .

(1) The Thesis consists of a contribution to the Study of Psychoses in Young People, with Special Reference to Prognosis.

(2) The Psychoses are considered in relation to the Life-situation, as a part of the interplay between the individual endowment and the environmental circumstances.

(3) Various questions are first put with regard to what can be ascertained from such a study in relation to prognosis. The features in the environment, in the psychosis and in the individual character and personality are considered both separately and in their relations to each other.

(4) The information that can be ascertained from a historical survey is first considered. This consists of the views on prognosis of various psychiatrists, special regard being paid to the views of Adolf Meyer, as revealed in his papers of 1906, of 1917 and of 1922. The Recovered Cases of schizophrenia, which have been reported during the past 30 years are included in this survey.

(5) There follows a discussion on the naming of psychotic states in young people in view of the varying/

varying tendencies in psychiatric nomenclature during the past 50 years.

(6) Cases are then reported in Two Groups.

(7) With regard to the first Group of cases occurring in adolescence mainly of a stuporose character, the influence of the environment to which the patient has to return is particularly considered, as are also the features of the psychoses - hysteroid elements, affect, regression. The importance of acute onset is considered. The adequacy of the previous personality is also considered, regard being paid to the adolescent condition of the patients under review. With regard to two of these cases, which in which the course is of particular interest, the sequence of phases in the illness is reviewed and the prognostic significance of such a sequence assessed.

(8) With regard to the Second Group of cases, in which the patients were in the third decade, there is more opportunity for discussing their relationship between the prognosis, the adequacy of the pre-psychotic character and the environmental social relationships. With regard to some of these cases, the question of belief is particularly considered, in relation to the beliefs of individuals in the environment and to normal belief./

There is a digression on the importance of assessing normal belief and of present-day tendencies in changing beliefs. With regard to other cases, the patients being natives of the Orkney Islands, the relationship between the psychotic response and the whole tendency of normal environmental response is considered, rather than the limited question of response as it affects beliefs, and their evolution into delusions.

Finally, the relationship between the Life-situation and the schizophrenic process is considered, and the importance of the psychoses showing a gross distortion of the personality is emphasised.

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